HEALTH PRACTICE INDICES 1943-44

AMERICAN PUBLIC HEALTH ASSOCIATION
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A Collection of Charts Showing the Range of Accomplishments in Various Fields of Community Health Service

COMPILED FROM THE EVALUATION SCHEDULES
Submitted for the years 1943 and 1944

Prepared by the
SUBCOMMITTEE ON STATE AND LOCAL
HEALTH ADMINISTRATION
for the
Committee on Administrative Practice of the
American Public Health Association
August 1945

ACKNOWLEDGMENTS

The Committee on Administrative Practice is deeply indebted to the Commonwealth Fund for making possible the publication of this book.

This analysis of public health activities was carried out under the direction of GEORGE T. PALMER, DR. P.H., Associate Field Director of the A.P.H.A. The compilation of material, computations, and drafting of charts were done by ERMINIE CROSS LACEY.

COOPERATIVE PROGRAM ON EVALUATION WITH STATE DEPARTMENTS OF HEALTH

States Participating

Alabama	Michigan
Arkansas	Mississippi
California	Oklahoma
Connecticut	Oregon
Illinois	Tennessee
Kansas	Texas
Kentucky	Washington
Louisiana	West Virginia
Massachusetts	Wisconsin

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INTRODUCTION

PRESENTED in this book are 71 individual line charts showing the range of health practices in the years 1943 and 1944 among 243 communities spread over 32 states and 4 provinces of Canada. The data are taken from schedules submitted by local health officers to the American Public Health Association for evaluation.

If a community submitted schedules both for 1943 and 1944, only the latter year was used.

The figures used in computing ratios are those recorded in the schedules. If the original material indicated that the item had been misunderstood or that the data were obviously incorrect, where time permitted inquiries were made so that entries could be corrected.

It should be emphasized that the Evaluation Schedule is designed to reveal the health protection of a community as a whole. The data should cover the activities of private practitioners and voluntary nursing and other agencies, and not just the work of the health department alone.

These charts will be found useful to local and state health officers, to other public health personnel, and to citizens generally in comparing local experience with a large sampling of practices over the United States and Canada. The local health officer can indicate on each chart the standing of his community and in a few minutes discover items of service which are far below average. This should show where emphasis is needed for improvement. Several health officers, using similar books previously published and covering practices in 1941-1942 and 1943, found it helpful in their educational program to republish or to make lantern slides of some of the charts in which they had inserted the standing of their own community. This visualization of local achievement has proved to be effective with both lay and professional audiences.

State directors of local health service as well as bureau directors of specialized services will find that the listing of the various indices of health practice for each individual community and the relative standing of each community in the charts will provide data of particular interest to them. The inventory serves as a basic plan on which to build improvement. It provides knowledge of the existing situation which is essential as the starting point for corrective steps. A state director of local health service with such a listing can discuss a local situation with pertinent facts

at his command and with similar facts from other communities as a comparative background.

The charts should also be illuminating to students in universities and other educational institutions where courses in public health are being given.

EXPLANATION OF CHARTS

Each line on a chart represents a separate community. The charts have been drawn so that the communities with the highest ranking practices or the lowest morbidity and mortality rates appear at the top.

Because the median and quartiles were determined only for communities which furnished data for a given chart, a "base" line has been drawn on each chart to indicate that the median and quartiles have been determined from the standing of communities above that line. Below the base line are indicated the number of communities whose data were inapplicable or inadequate for the computation of the ratio. This arrangement indicates the extent to which certain types of data are not specifically known locally. Any community knowing its own index can readily determine its position on a chart.

However, to make this identification more simple a key folder has been inserted this year at the end of the book. Here is shown the relative standing of each of the 243 communities in each of the range charts. Instead of names of communities in the first column, numbers are used in order from one to 243. Each health officer has been informed of the identifying number of his community. Further explanation of its use will be found on the folder.

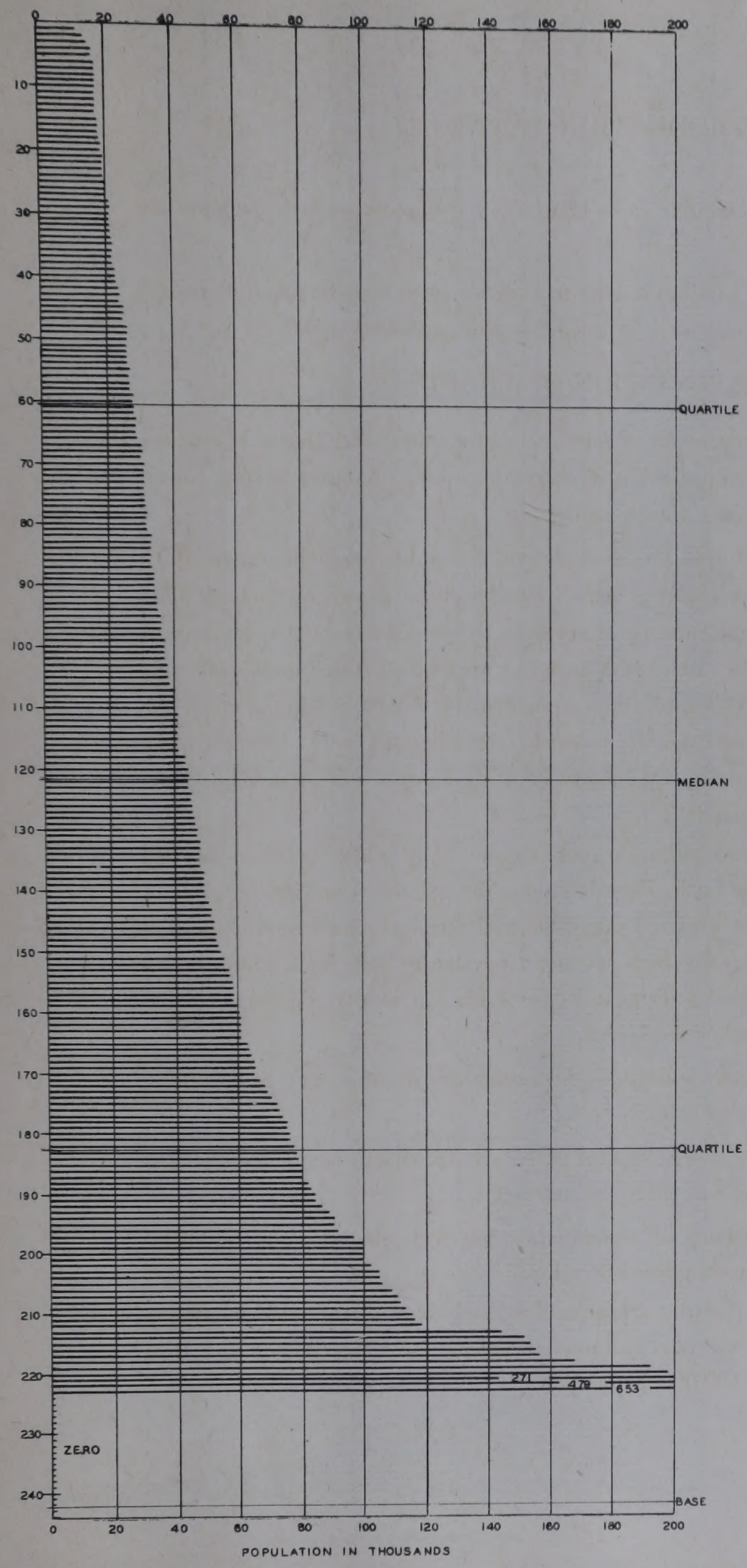
This group of communities constitutes the beginnings of what may be termed a *Reporting Area for Health Practices.*

In addition to the range charts, several pages are devoted to frequency distribution of data in the form of bar charts or statements.

The names and populations of communities which furnished data for these charts are listed in a table on pages 80 and 81.

Ranges, medians, and quartiles are given for each chart in the table beginning on page 82. In this table will also be found the median for 49 communities over 100,000 and 194 under 100,000 population.

POPULATION PER FULL TIME MEDICAL OFFICER



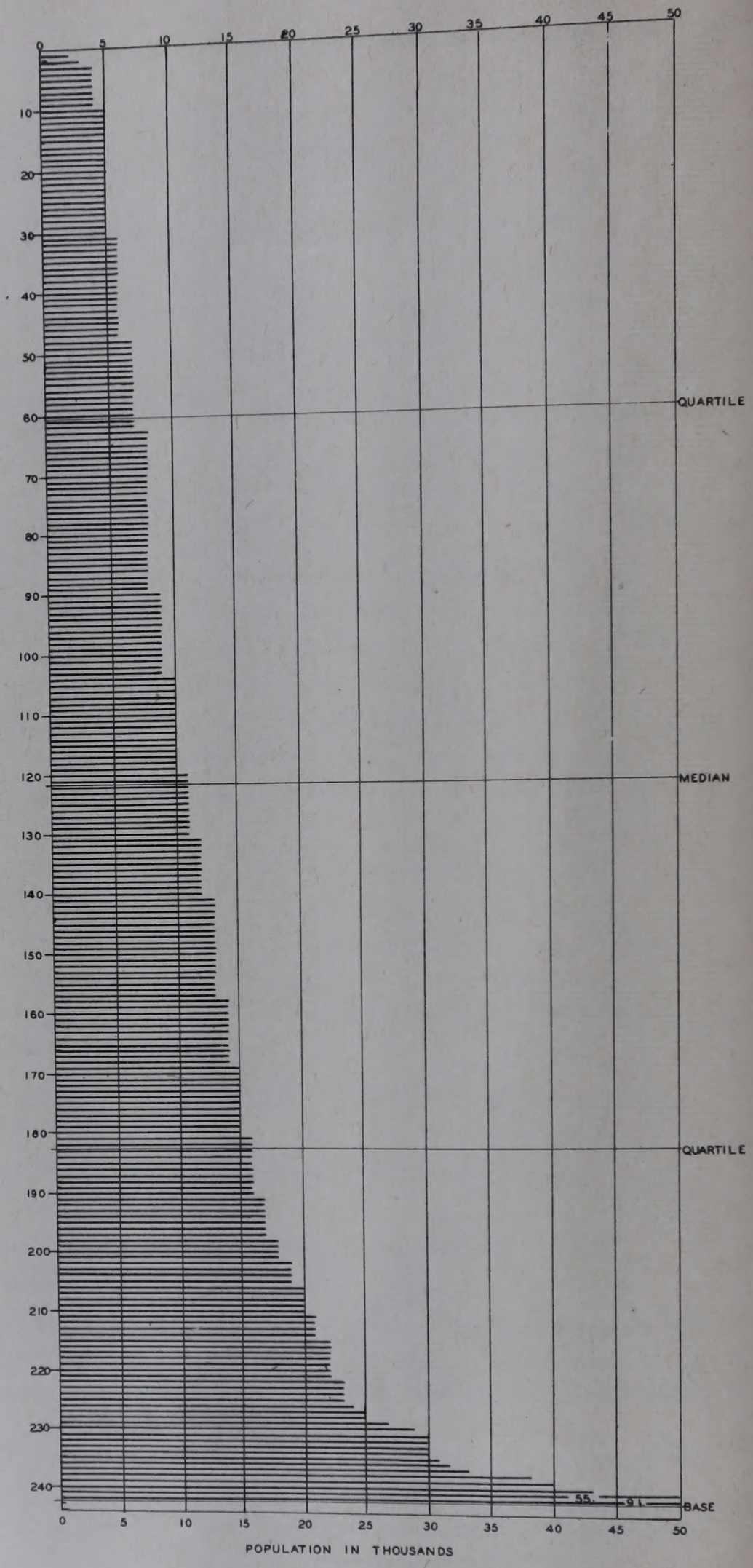
This chart covers only medical officers employed full time by health departments. In small jurisdictional units of less than 25,000 population, the health officer will be the only full time medical person. In larger areas will be found also full time deputy health officers, heads of different services and even clinicians on a full time basis. To the Subcommittee on Local Health Units of the American Public Health Association, it does not seem the most productive use of the time of a trained medical officer of health to limit his service to areas of less than 50,000 population. Areas near the bottom of the chart are however depending altogether too much on the part time, instead of the needed full time, of the medical officer.

HEALTH DEPARTMENT PERSONNEL

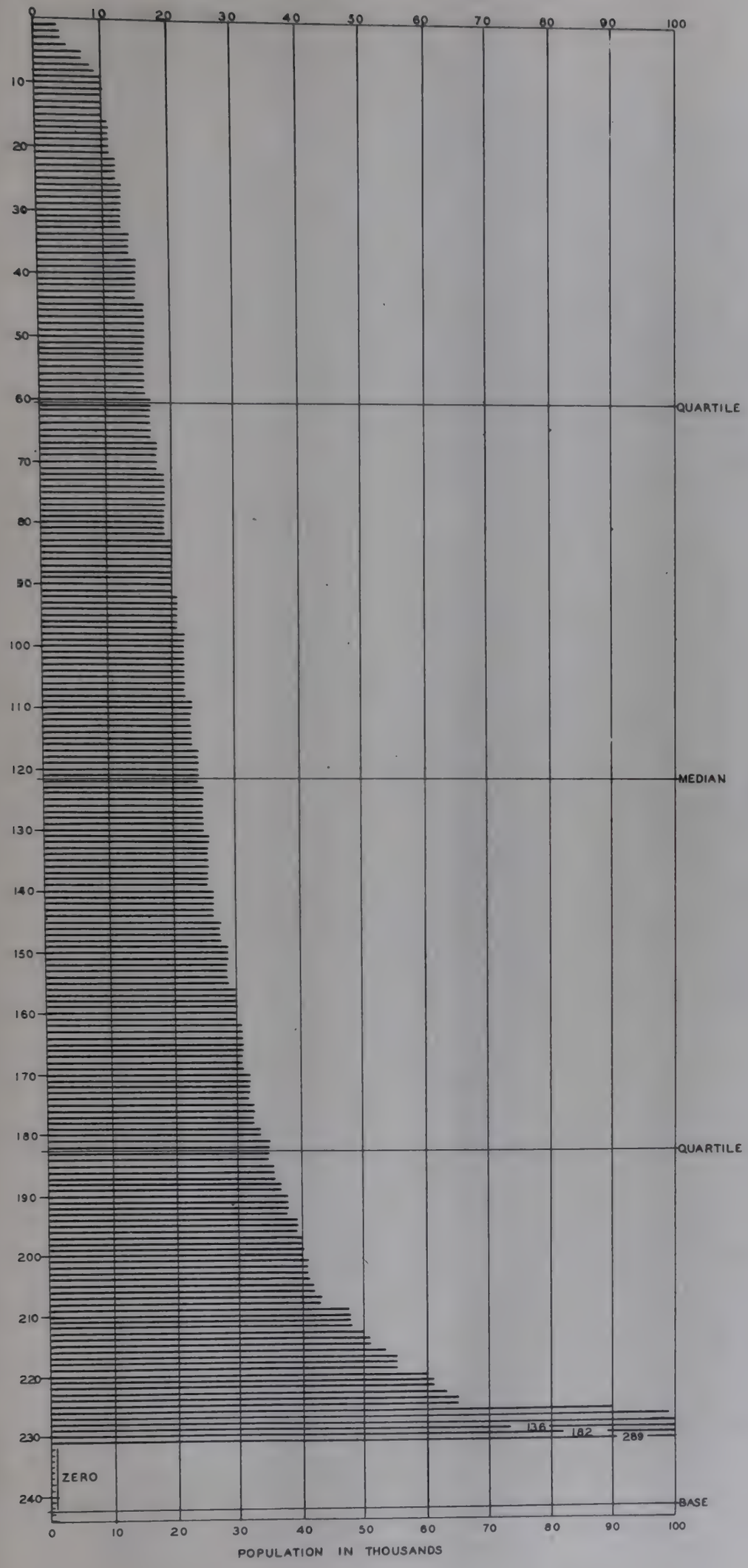
POPULATION PER FULL TIME PUBLIC HEALTH NURSE

Only one of the 243 communities reporting gave no data on personnel in the health department.

The median indicates a ratio of one nurse per 11,000 population. This is more than twice the load recommended in the war time standard of 5,000 population per public health nurse as set by the National Organization for Public Health Nursing. In no instance is the normal standard of one nurse to each 2,000 of the population attained. A comprehensive public health nursing program is out of the question in the communities in the lowest quarter of the chart. This deficiency is made up in some instances by public health nurses employed in other public or voluntary agencies. This fact is not disclosed in this chart however.



POPULATION PER FULL TIME SANITARIAN



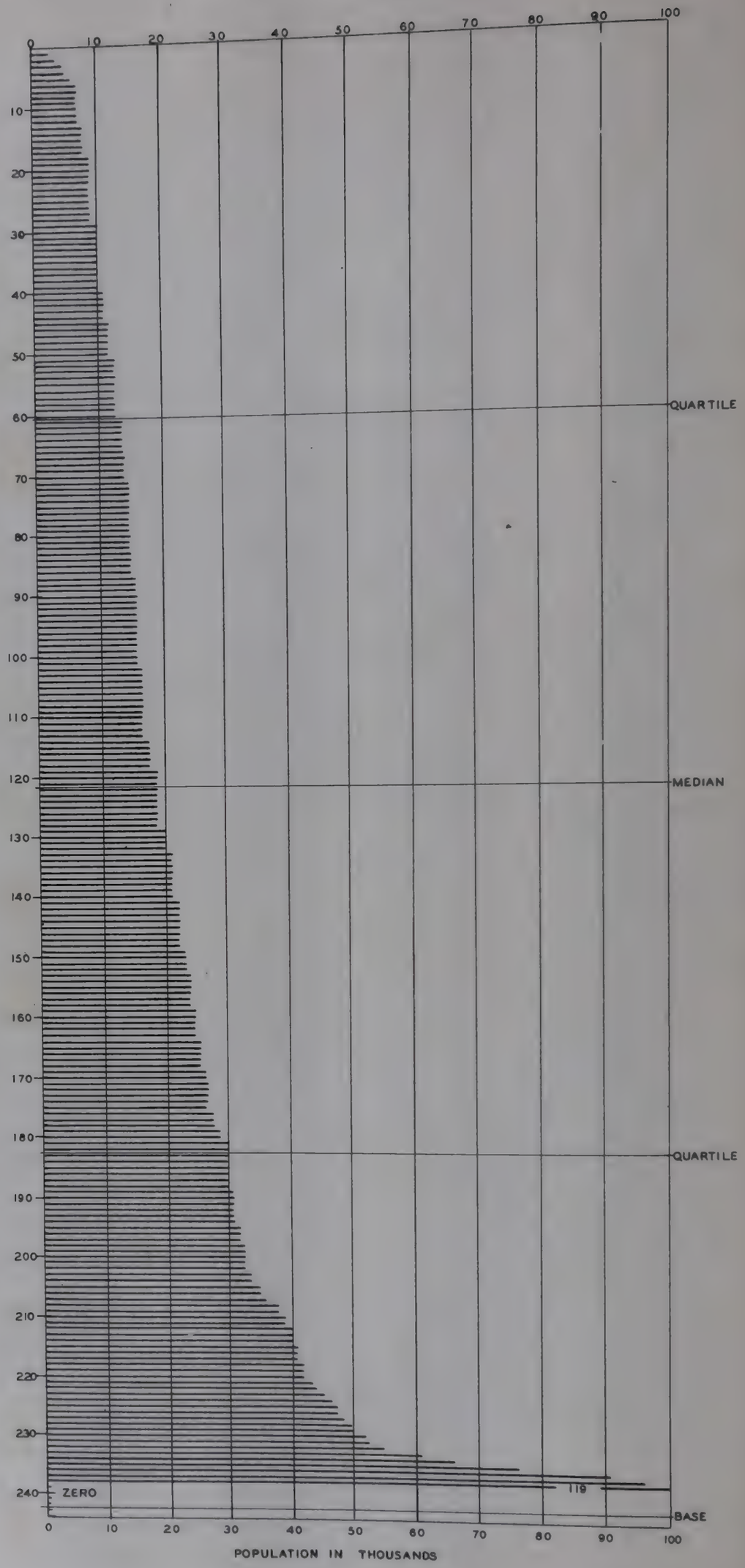
Because a department may have an engineer and no sanitarian or the sanitarian with no engineer, it was necessary here to combine public health engineers and sanitarians.

The median is one sanitarian to 24,000 population. The need for sanitarians will of course vary somewhat, depending on the local problems, particularly with reference to malaria or typhus control work or responsibility for foodhandling inspection. The above median however is in accord with the recommendations of a committee of the A.P.H.A. which specify one sanitarian for 25,000 population. While some communities do much better than this (perhaps more than is really necessary) there are areas in the lower part of the chart where the number of sanitarians is grossly inadequate.

POPULATION PER FULL TIME CLERK

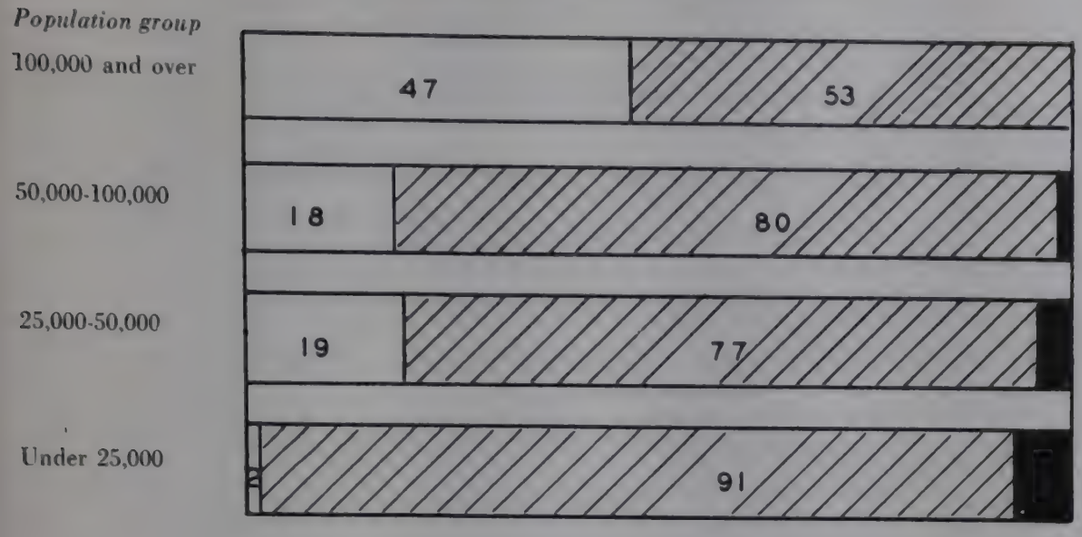
The efficient use of clerical service will save the time of professional people. The inescapable load of clerical work in a health department which is basic to the whole health program necessitates an adequate staff of clerks. The median is one clerk for a population of about 18,600 people. The lower ranges of the chart show a definite inadequacy of clerical service. It is uneconomical, to say the least, to force this work upon the professional staff.

The lack of clerical service is reflected again and again in the charts of this book by the great number of communities whose data were either altogether lacking or too incomplete for analysis.

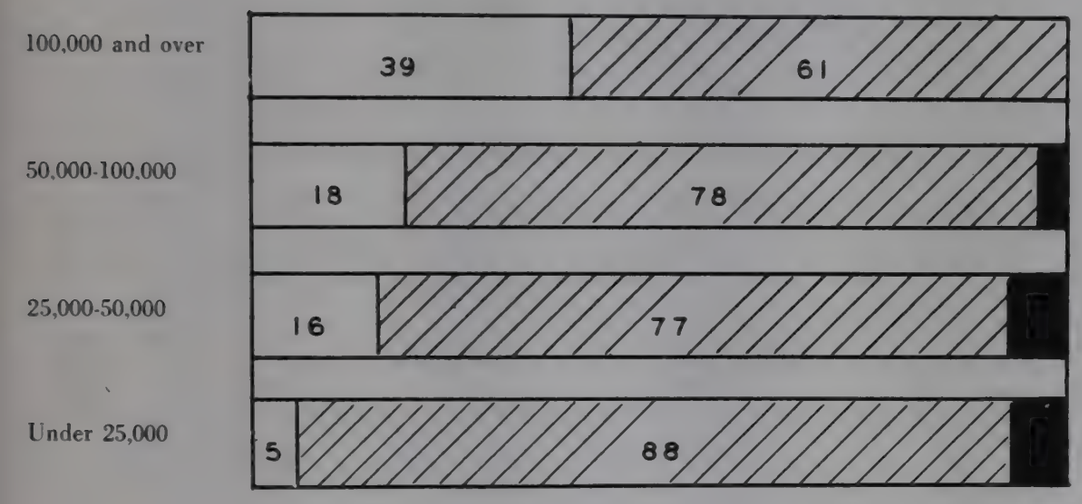


HEALTH DEPARTMENT PERSONNEL

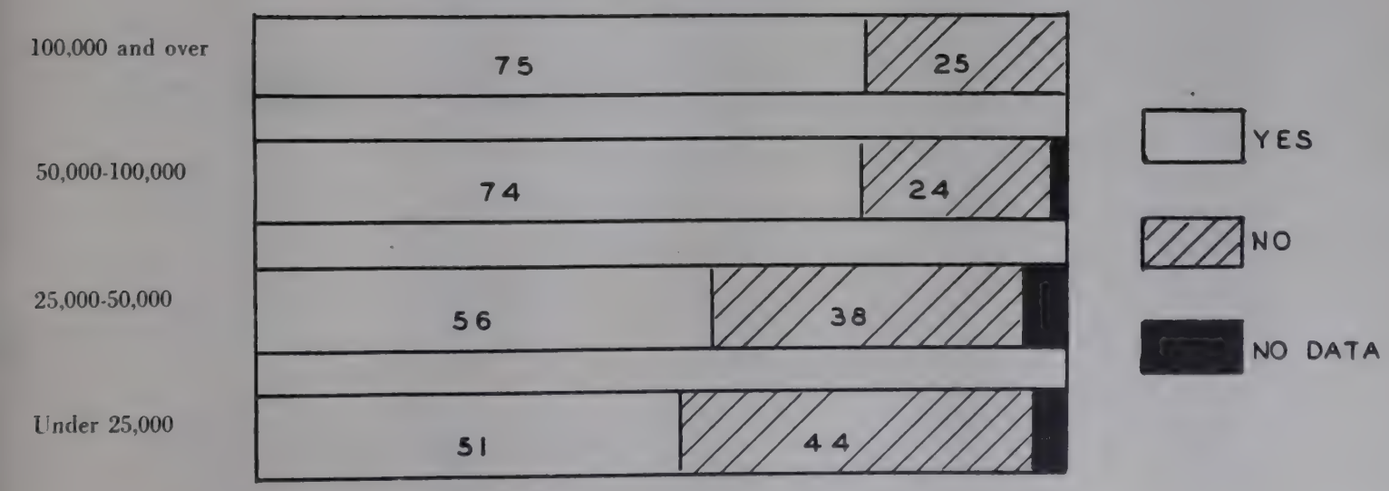
PENSION OR RETIREMENT SYSTEM: PERCENTAGE OF COMMUNITIES REPORTING



AGE LIMIT FOR RETIREMENT: PERCENTAGE OF COMMUNITIES REPORTING



SALARY INCREMENT LINKED TO PERSONNEL CLASSIFICATION PLAN: PERCENTAGE OF COMMUNITIES REPORTING



Stabilization of staff is greatly aided by the establishment of pension and retirement provisions, a clearly thought out plan of salary levels in conformity to the varying responsibilities and training required for the job, and a recognized method of salary increments. For efficiency in health service to the people of the community an age limit for retirement should be fixed.

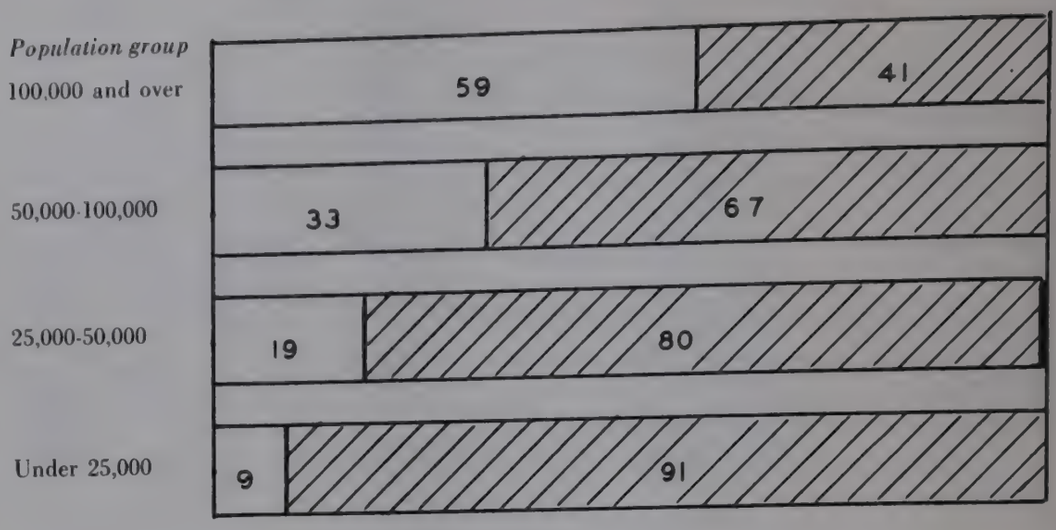
In general the larger the community, the more consideration given to these personnel policies. The plan of salary increments and job classification has received more consideration than pensions or age limits for retirement.

In the population group of 100,000 there were 49 areas reporting; 50,000-100,000, 49 areas; 25,000-50,000, 102 areas; under 25,000, 43 areas.

HEALTH DEPARTMENT PERSONNEL

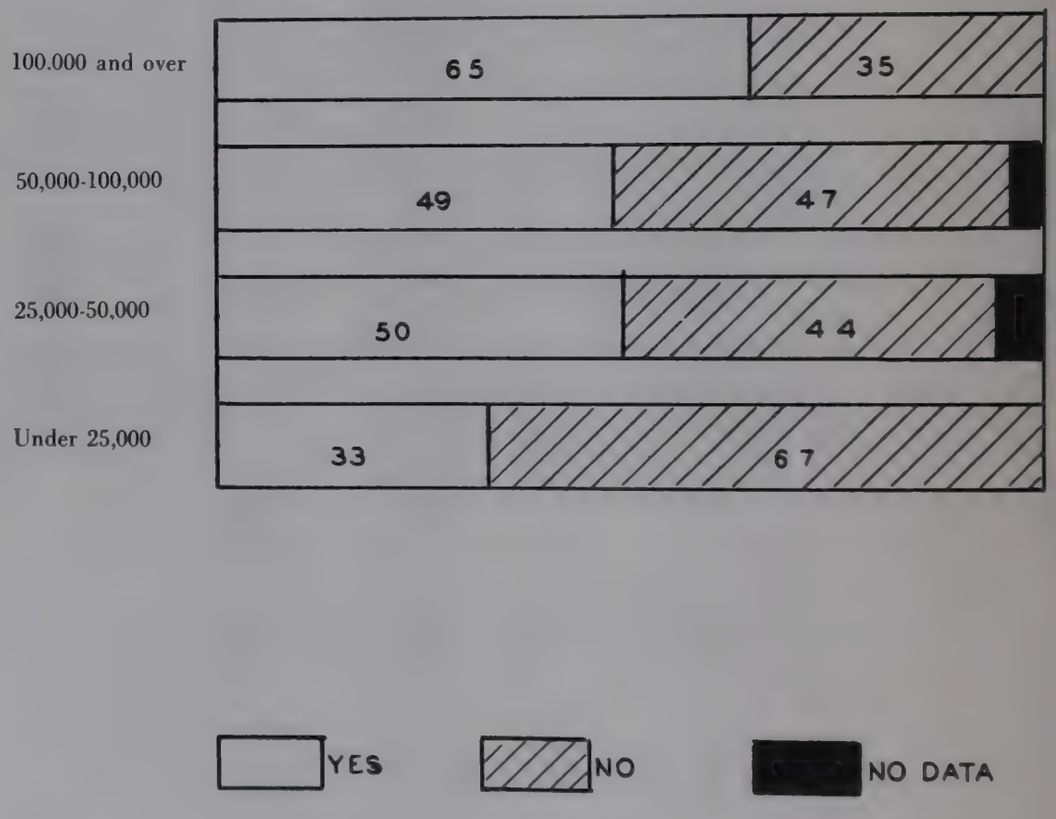
PUBLIC HEALTH ENGINEER ON STAFF: PERCENTAGE OF COMMUNITIES REPORTING

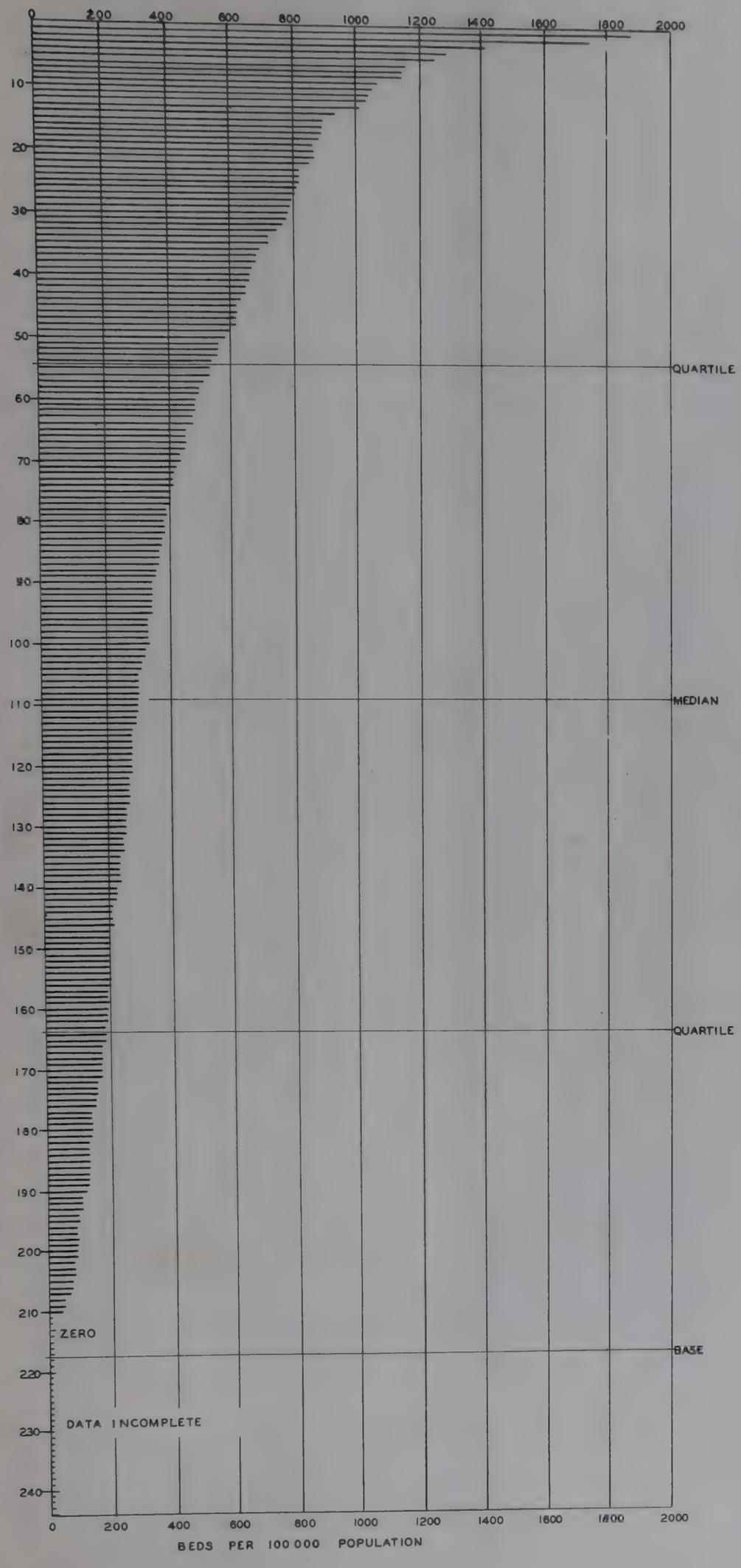
The need for a public health engineer is more keenly appreciated the larger the community. Problems requiring engineering consideration are more numerous there. But even in smaller areas there will be found troublesome technical problems in which the judgment of the trained public health engineer can be of the greatest aid. This is indicated by the presence of the engineer in a number of communities of less than 50,000 population.



REGISTRAR OF VITAL STATISTICS ON STAFF: PERCENTAGE OF COMMUNITIES REPORTING

Records of births and deaths are of primary interest to the health department. For this reason it is highly desirable that a health department staff member serve as registrar. This will mean that records are readily accessible and that proper attention is given to the accuracy and completeness of data on the birth and death certificates.





BEDS PER 100,000 POPULATION

The hospital section of the U. S. Public Health Service has recently set the need for general hospital beds at 4.5 per 1,000 of the population. The median shown in this chart is 3.0 per 1,000 (actually 297.0 per 100,000) or considerably below the standard. These data must be regarded as a general approximation because the methods of determining available beds are probably not uniform. Some areas at the top of the chart may serve populations in outlying areas. Some of those at the other extreme of the chart may have reported few available beds locally, and yet the people may be served with some adequacy in adjacent territory.

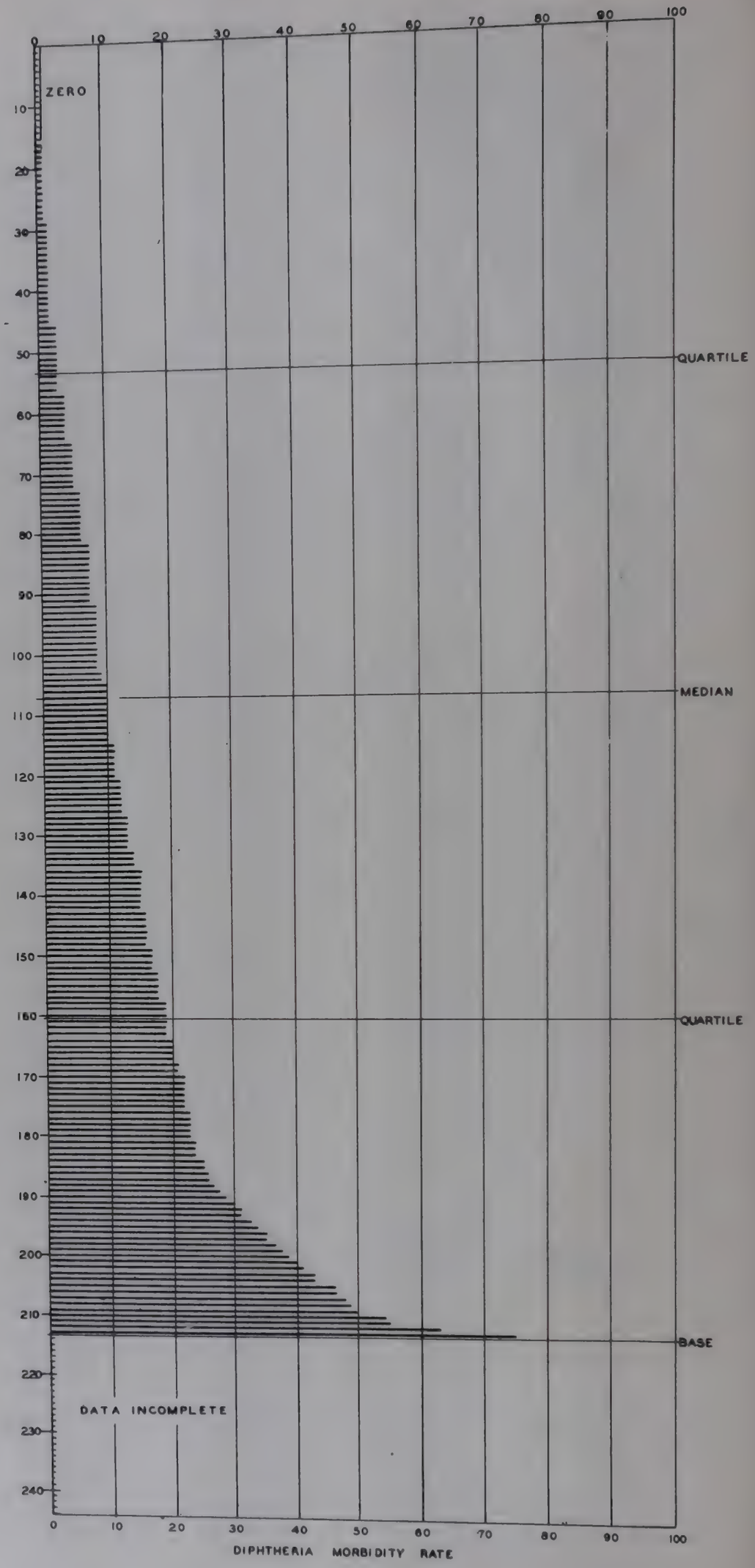
As would be expected, beds are more plentiful in the larger communities, the median being 438. as compared with 263. in smaller areas.

COMMUNICABLE DISEASE

DIPHTHERIA CASES PER 100,000 POPULATION

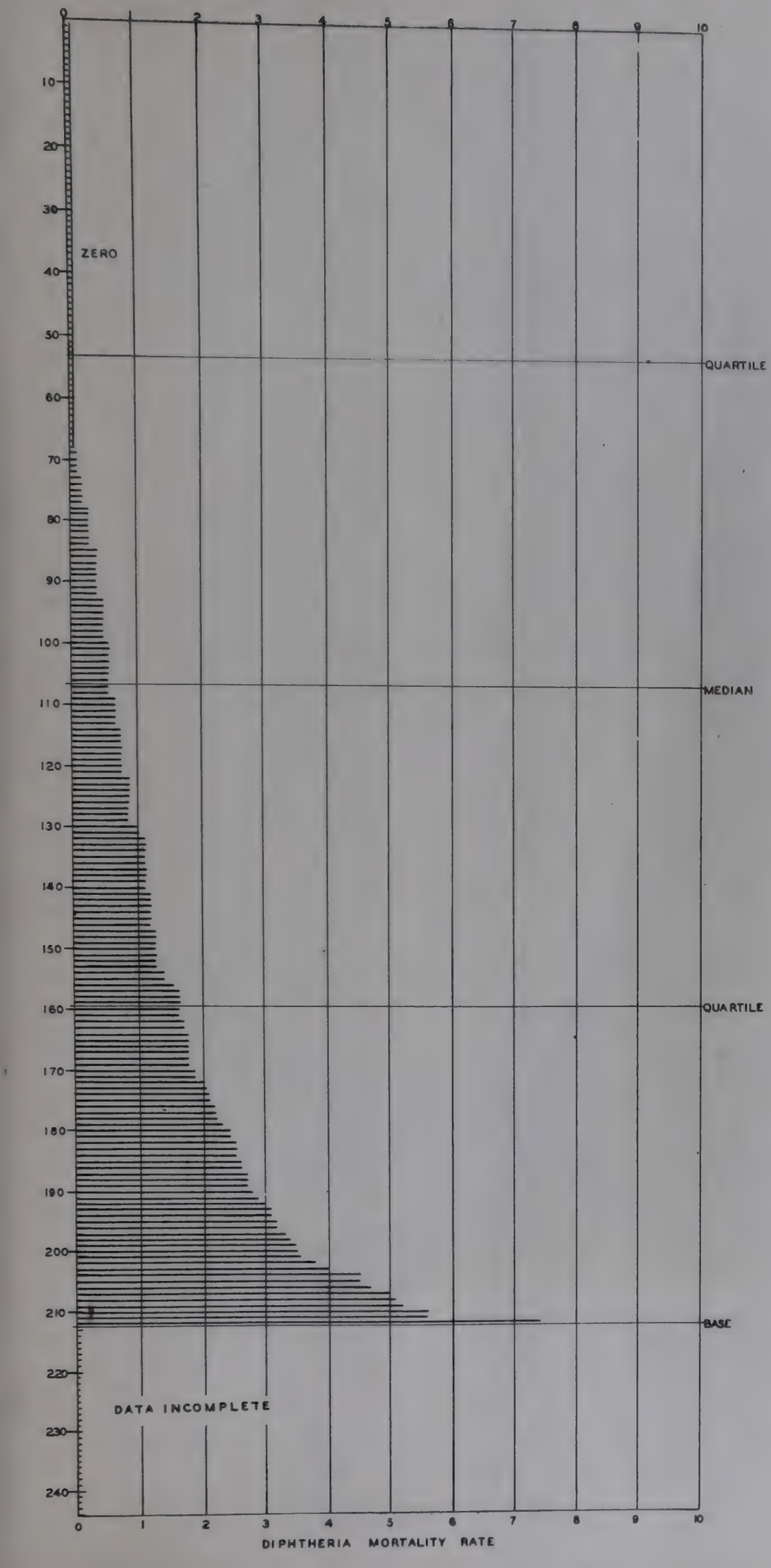
FIVE YEAR PERIOD

Of 213 communities submitting data on diphtheria cases over the last five years, 15 report no diphtheria whatever in this period. The median rate is 9.7 per 100,000 population. In the "Indices" for last year the median was 8. A marked increase in diphtheria in 1944 was reported in a number of communities. There were 30 areas that were unable to report these data for the five year period.



DIPHTHERIA DEATHS PER 100,000 POPULATION

FIVE YEAR PERIOD

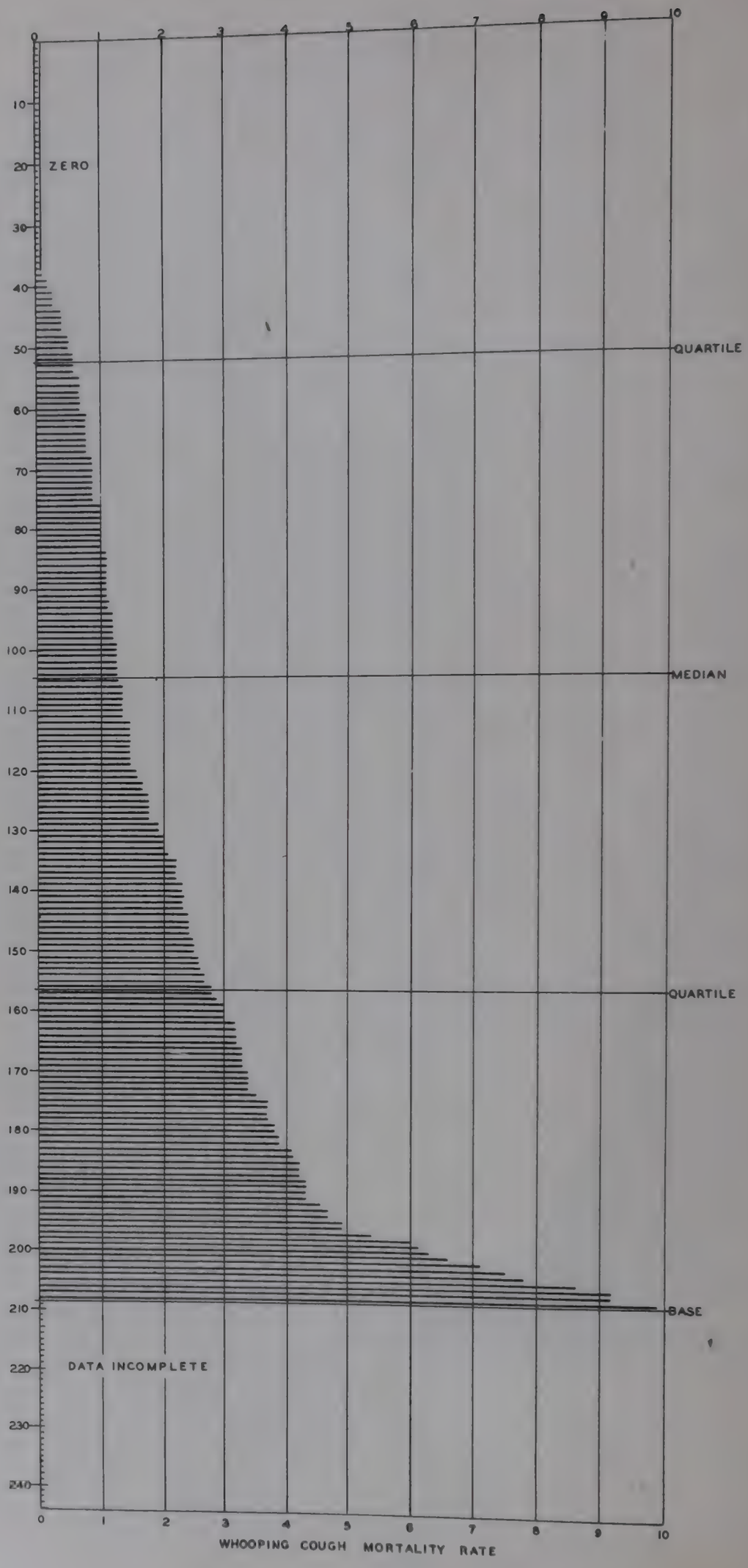


Sixty-eight communities reported no deaths from diphtheria in the last five years. However, the significant feature of this chart is that diphtheria is by no means a negligible factor in mortality. Many communities still have substantial rates. More widespread immunization of babies and young children is necessary to meet this issue. The median death rate is 0.6 or slightly below the figure of 0.9 for the United States as a whole in 1943.

WHOOPING COUGH DEATHS PER 100,000 POPULATION

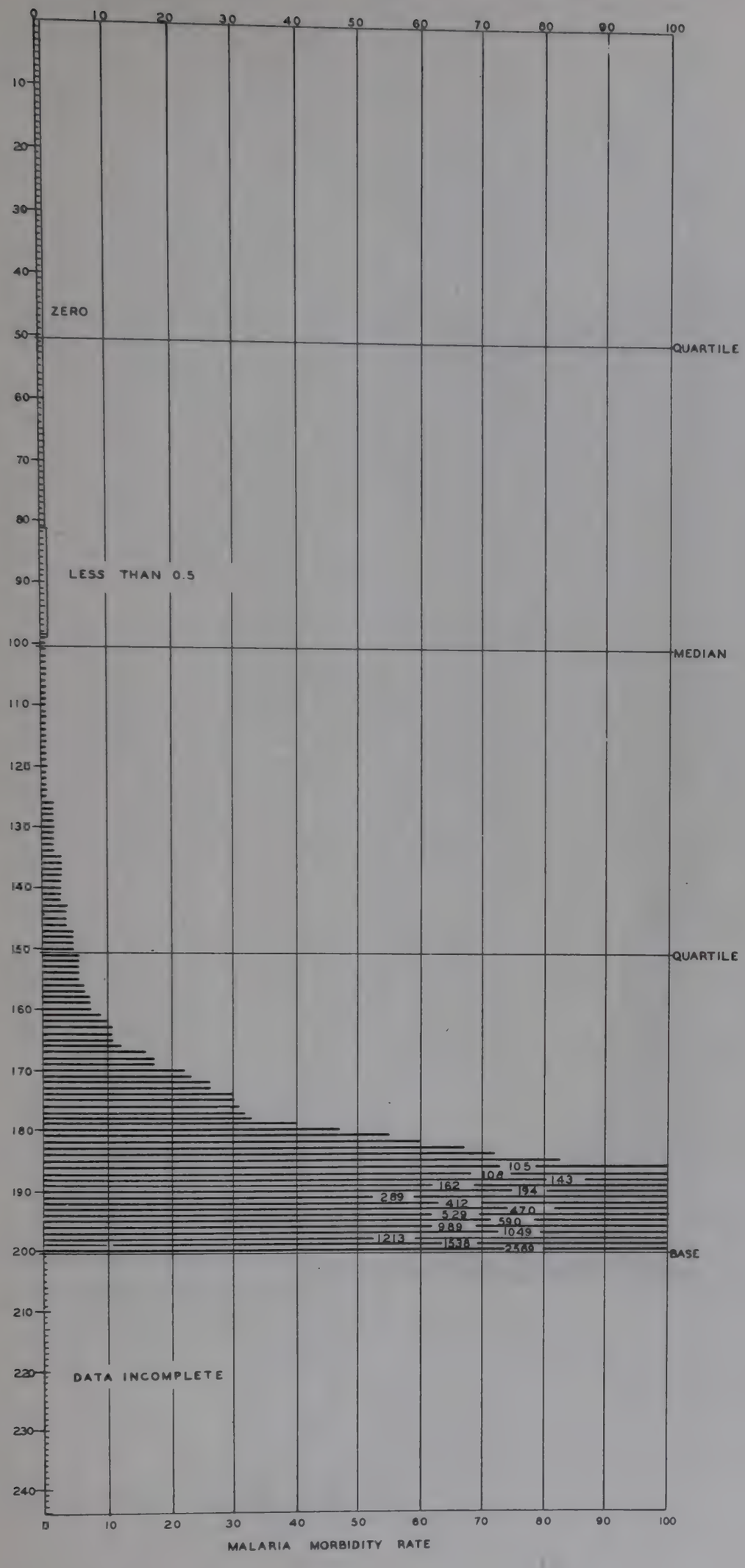
FIVE YEAR PERIOD

Mortality from whooping cough shows a median rate of 1.3 per 100,000 for the five year period. This may be contrasted with the rate of 0.6 for diphtheria. Among professional people there is a prevailing opinion that whooping cough vaccine is effective in preventing mortality, particularly among very young children where most of these deaths occur. The median rate of 1.3 for this group of communities is appreciably less than the rate of 2.5 for the United States in 1943.



MALARIA CASES PER 100,000 POPULATION

FIVE YEAR PERIOD

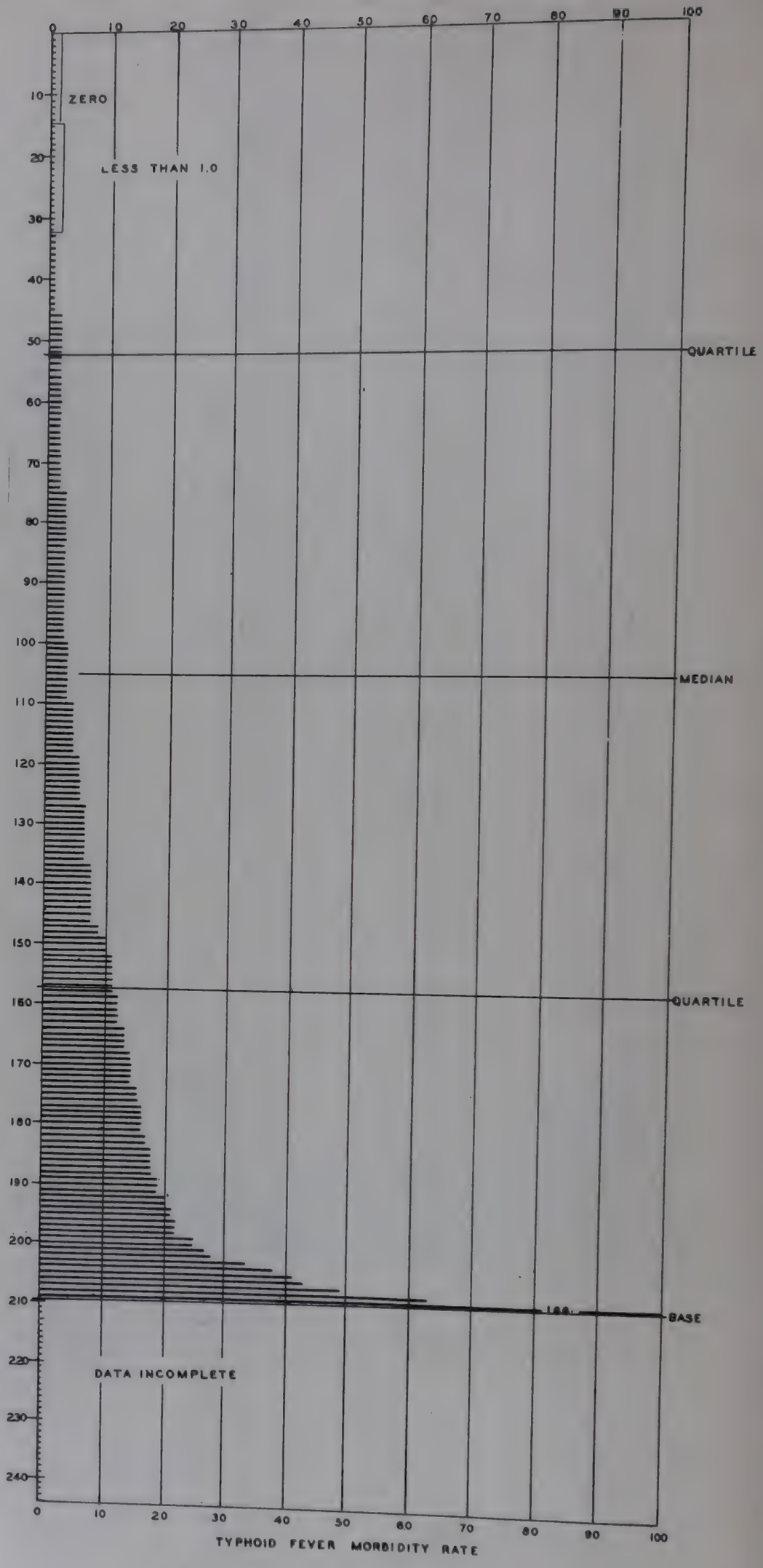


More communities with malaria are shown in this chart than a year ago. The highest rate for the five year period shown last year was 1,063. per 100,000 population. This year three communities with still higher rates appear, the highest amounting to 2,569. While malaria is a real problem in relatively few communities, the control measures necessitated in the heavily infected areas are costly and frequently require financial aid beyond the resources of the local area. The use and results of DDT will be of particular interest to the health officers of the communities in the lower quarter of the chart.

TYPHOID FEVER CASES PER 100,000 POPULATION

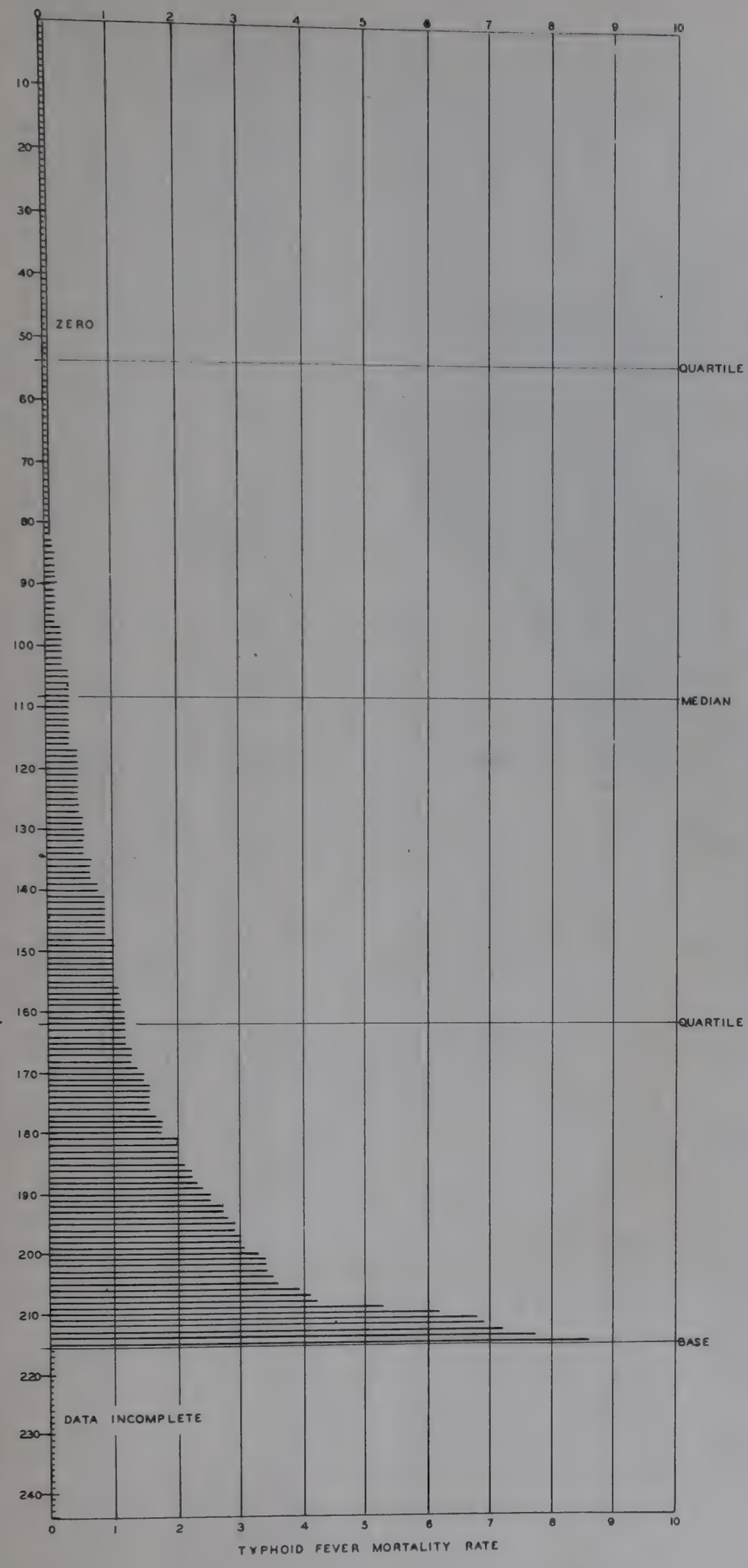
FIVE YEAR PERIOD

The typhoid fevers are relatively infrequent in a majority of communities in this chart. However, there are areas at the bottom of the chart where the problem is still acute, one area in particular having a rate of 166. per 100,000 population. The median rate over the last five years is 4.2 or about the same as shown in the "Indices" of last year. Thirty-four communities could not provide the necessary data.



TYPHOID FEVER DEATHS PER 100,000 POPULATION

FIVE YEAR PERIOD



The median is 0.4 deaths per 100,000 population, the same as last year. Typhoid mortality is still a public health problem in a considerable number of communities. While the median *case* rate for smaller communities (under 100,000 population) is 4.4 against 3.4 for larger areas, the median *death* rates are the same, 0.4.

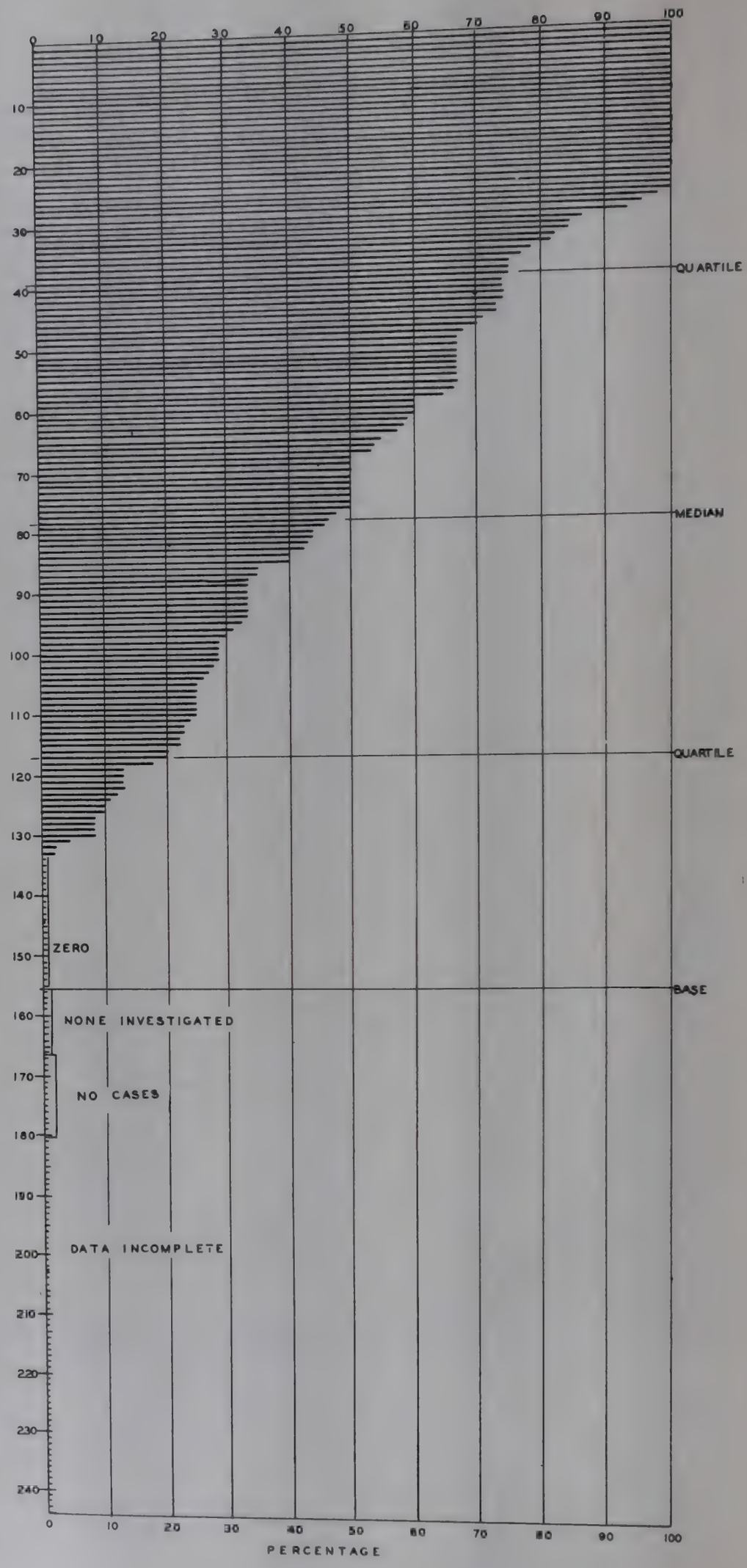
TYPHOID AND PARATYPHOID FEVERS INVESTIGATED

PERCENTAGE OF SOURCES FOUND

FIVE YEAR PERIOD

While the identification of the source of the infection is often difficult, this chart is disappointing in revealing so many instances where either no sources were found, or no investigations were made or no information is available on the subject. To control these diseases, there is need for thorough epidemiological work.

The median (59.) for the larger communities is greater than that for the smaller areas (42.).



COMMUNICABLE DISEASE

RESTRICTIONS ON TYPHOID CARRIERS: PERCENTAGE OF COMMUNITIES REPORTING

	POPULATION OF COMMUNITIES			
	100,000 *and over*	50,000-100,000	25,000-50,000	*Under* 25,000
Number reporting	49	49	102	43
Prohibited from working in foodhandling establishments				
Yes	98.0	91.9	89.2	86.1
No	0	2.0	1.0	2.3
Data incomplete	2.0	6.1	9.8	11.6
Prohibited from caring for children				
Yes	87.7	81.6	77.4	65.1
No	8.2	10.2	12.8	14.0
Data incomplete	4.1	8.2	9.8	20.9
Required to submit stools at least annually				
Yes	65.3	75.5	76.5	69.7
No	30.6	14.3	13.7	14.0
Data incomplete	4.1	10.2	9.8	16.3
Required to report change of address to health department				
Yes	91.9	89.8	84.3	79.1
No	6.1	4.1	4.9	4.6
Data incomplete	2.0	6.1	10.8	16.3

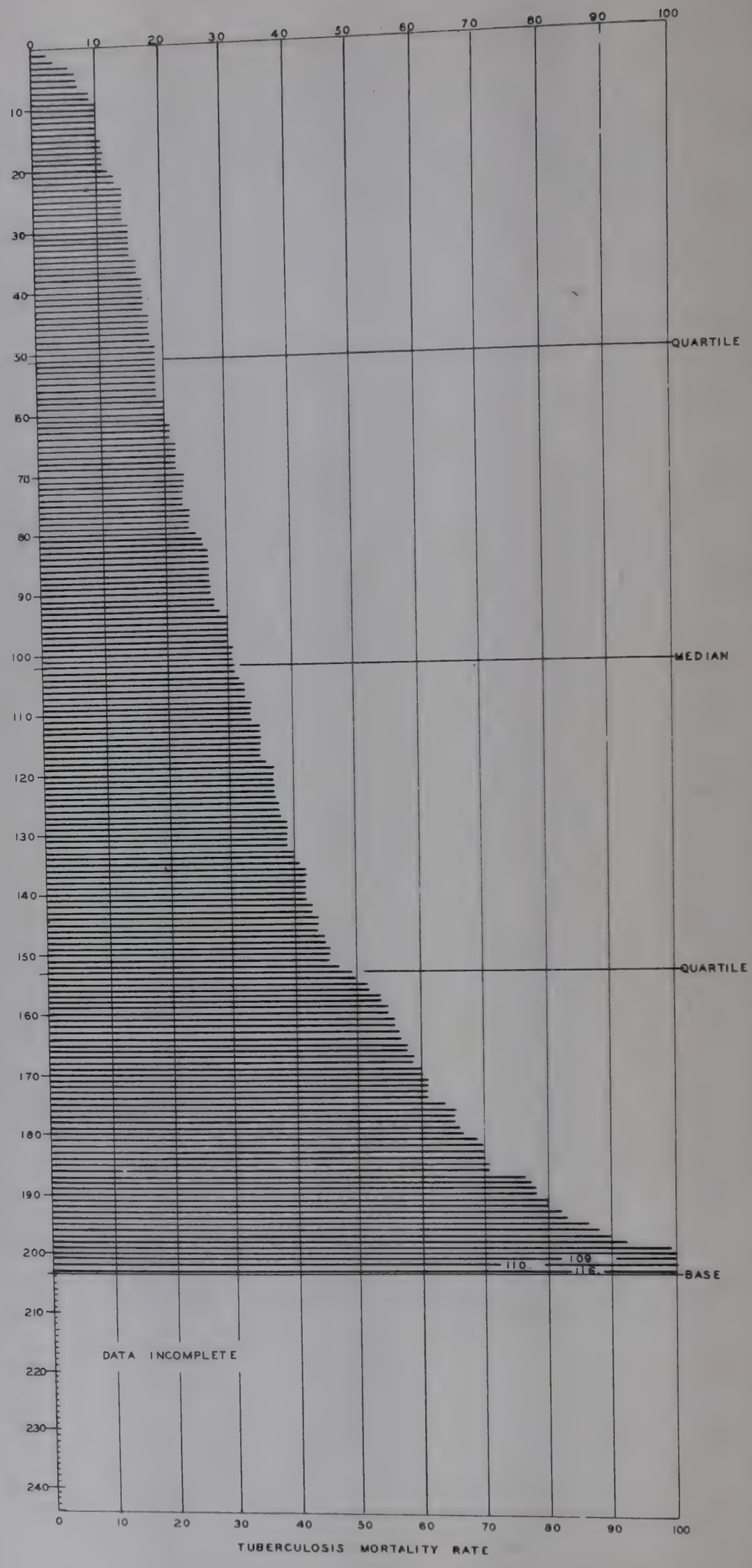
The first two and the fourth restrictions are more extensively followed, the larger the community. The third item, on submitting stools at least annually, is least common in the largest areas. The value of this requirement is open to debate. Perhaps the largest communities with broader experience have found valid reasons to question the necessity of this procedure.

TUBERCULOSIS

DEATHS PER 100,000 POPULATION

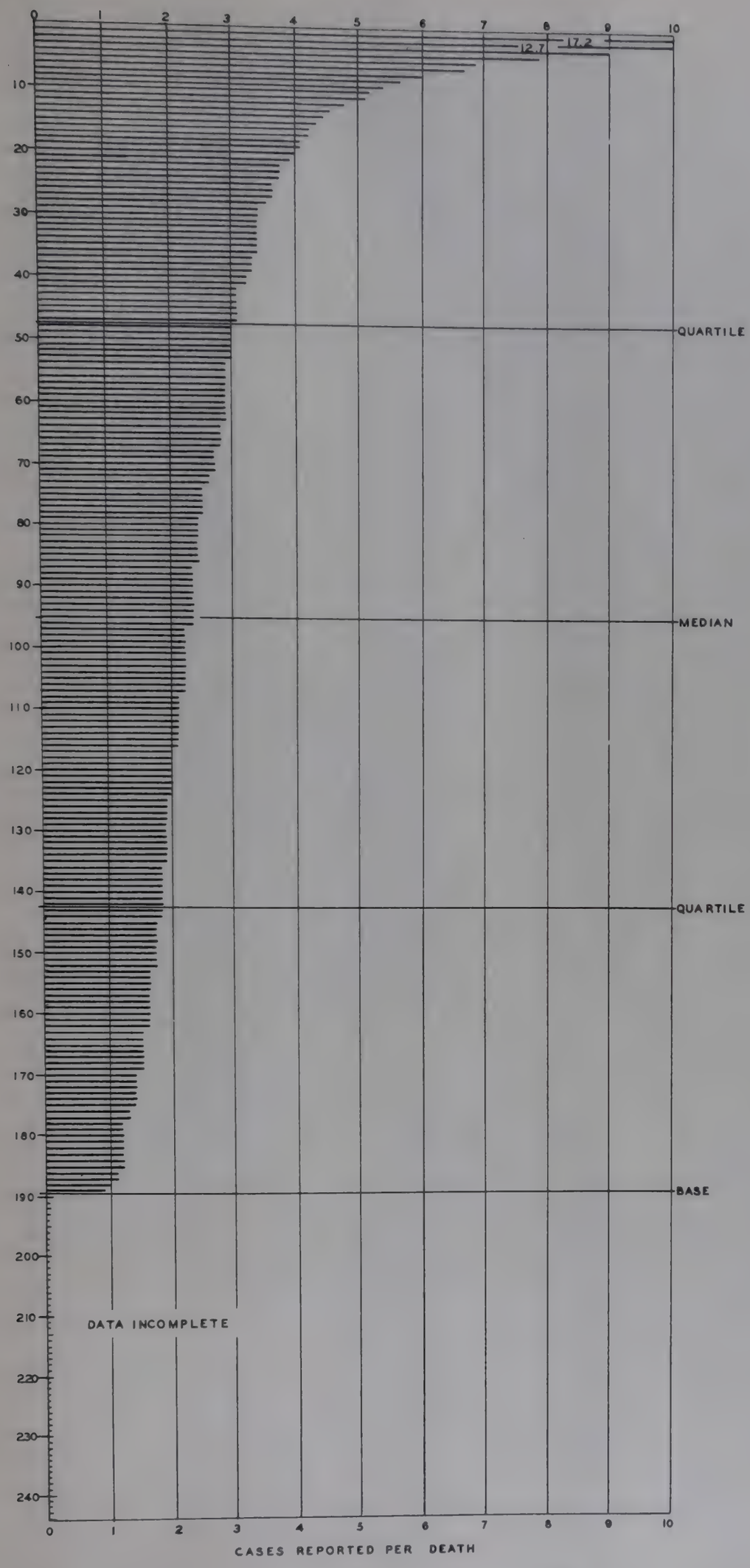
FIVE YEAR PERIOD

The rates here displayed may not be properly comparable with those published by the U. S. Bureau of the Census because the community may not have the full record of deaths of residents occurring outside the area. These rates do, however, represent the deaths known by the local health officer and from which his program is planned. The median for a five year period is 31.1 as compared with a death rate of 42.6 for the United States in 1943. The control problem facing those communities in the lower part of the chart is vastly greater than that of other communities shown.



CASES REPORTED PER DEATH

FIVE YEAR PERIOD

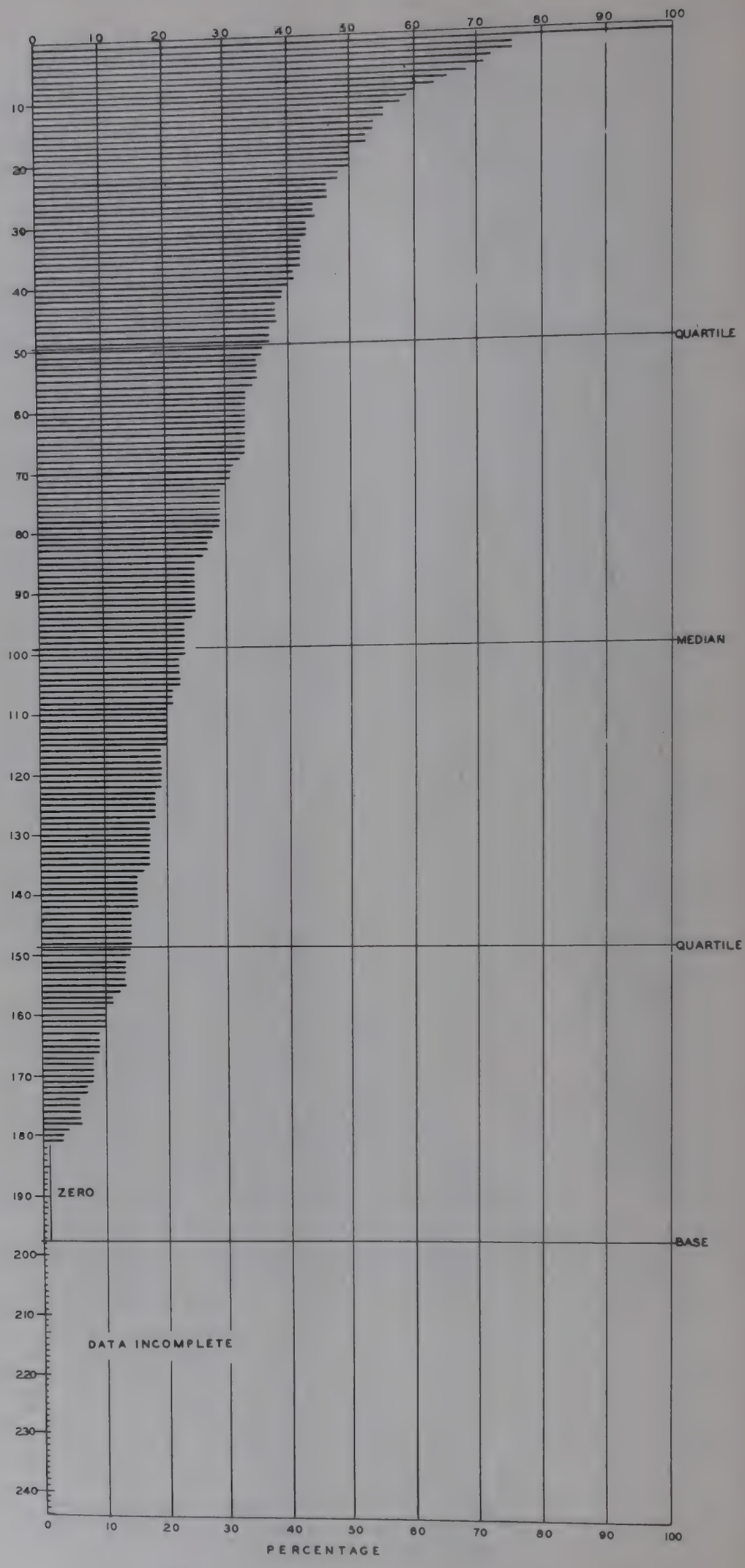


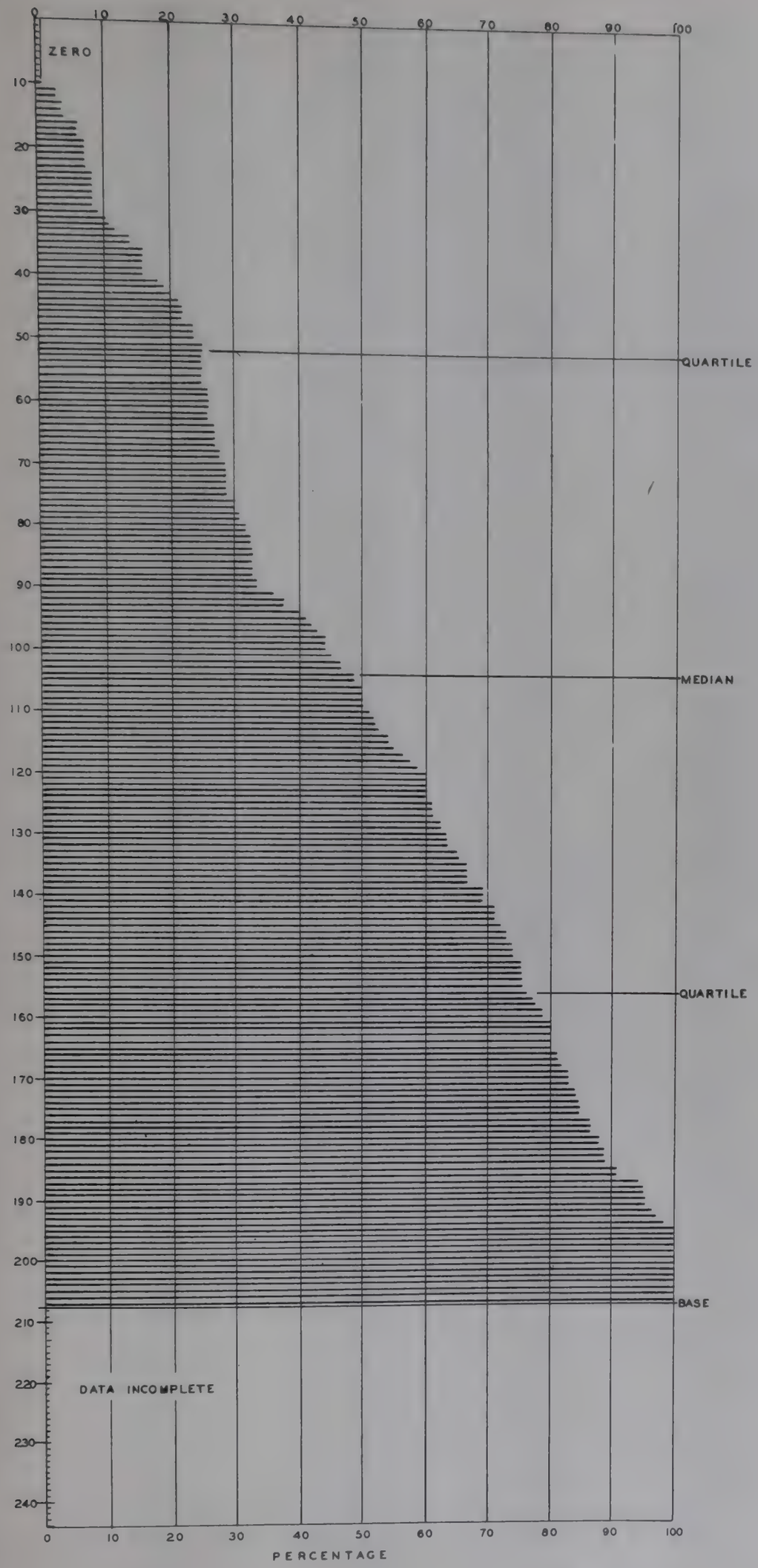
The median is 2.3 cases reported per death. The expected index would be three cases per death. The lower half of the chart at least reflects inadequate reporting of tuberculosis cases. Fifty-four communities have yet to find out what these basic facts are.

NEWLY REPORTED CASES

PERCENTAGE IN MINIMAL STAGE

When tuberculosis is reported in the early stages the chances of recovery are ever so much more promising. The smaller percentages of cases found in the minimal stage suggest an increased need of mass x-ray surveys of susceptible age and occupational groups. The median ratio for this group of communities is 23.1.





TUBERCULOSIS

ACTIVE CASES ON REGISTER

PERCENTAGE AT HOME AT END OF YEAR

This is a picture which indirectly portrays for the most part the lack of hospital beds for tuberculosis. To a lesser degree it also indicates the lack of success in getting cases to enter and remain in hospitals. On the average, nearly half of the active cases are still living at home; and in the lower ranges of the chart there are instances where every case is at home. This means that not a single active case has been hospitalized during the year. With perhaps a few exceptions every active case ought to be in a hospital, both for his own good and as a protection to the people at home and the community at large. In spite of the declining death rate from this cause, tuberculosis is still a major problem in all too many communities.

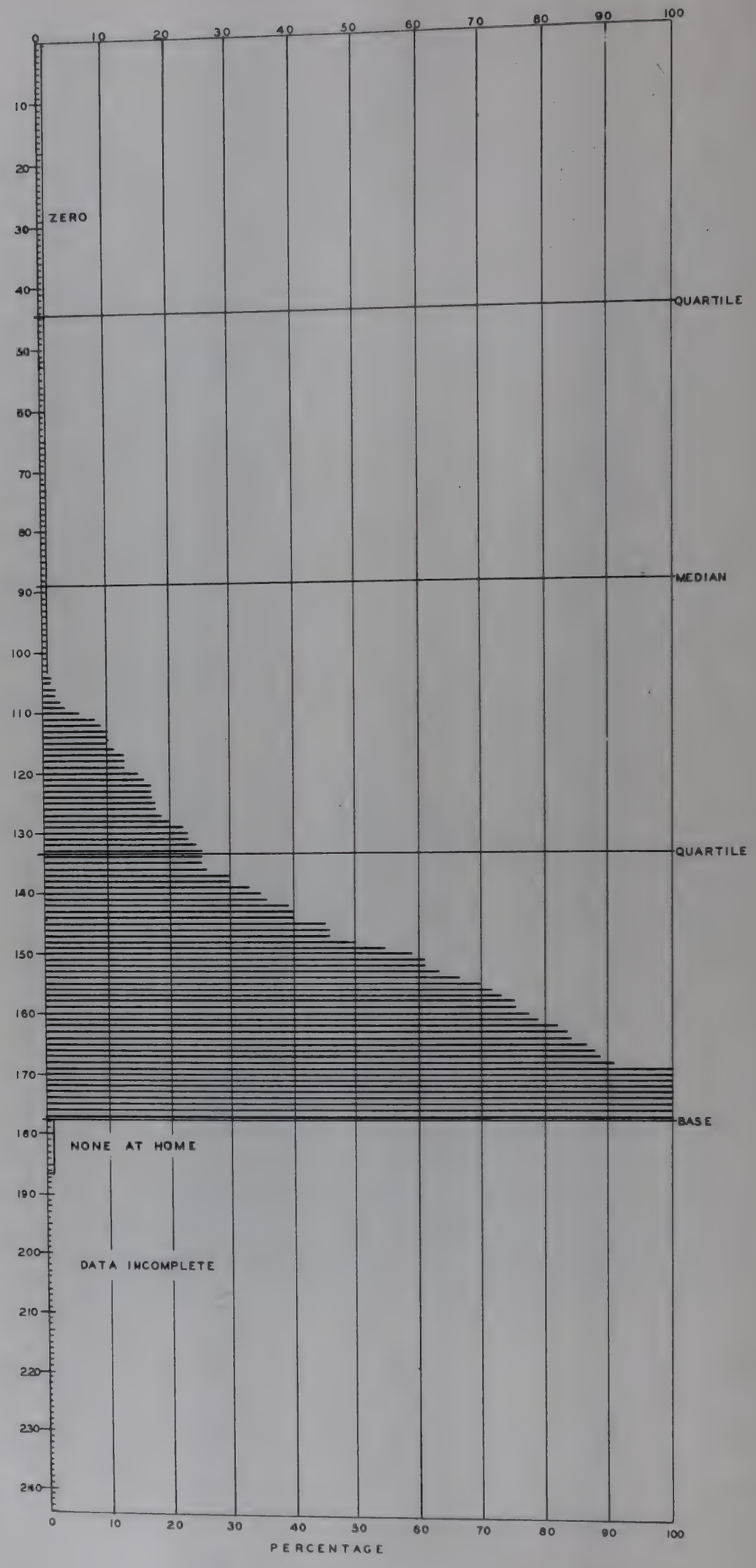
The larger areas (over 100,000 population) are only slightly better off than those below 100,000 population. The respective medians are 51. and 44.

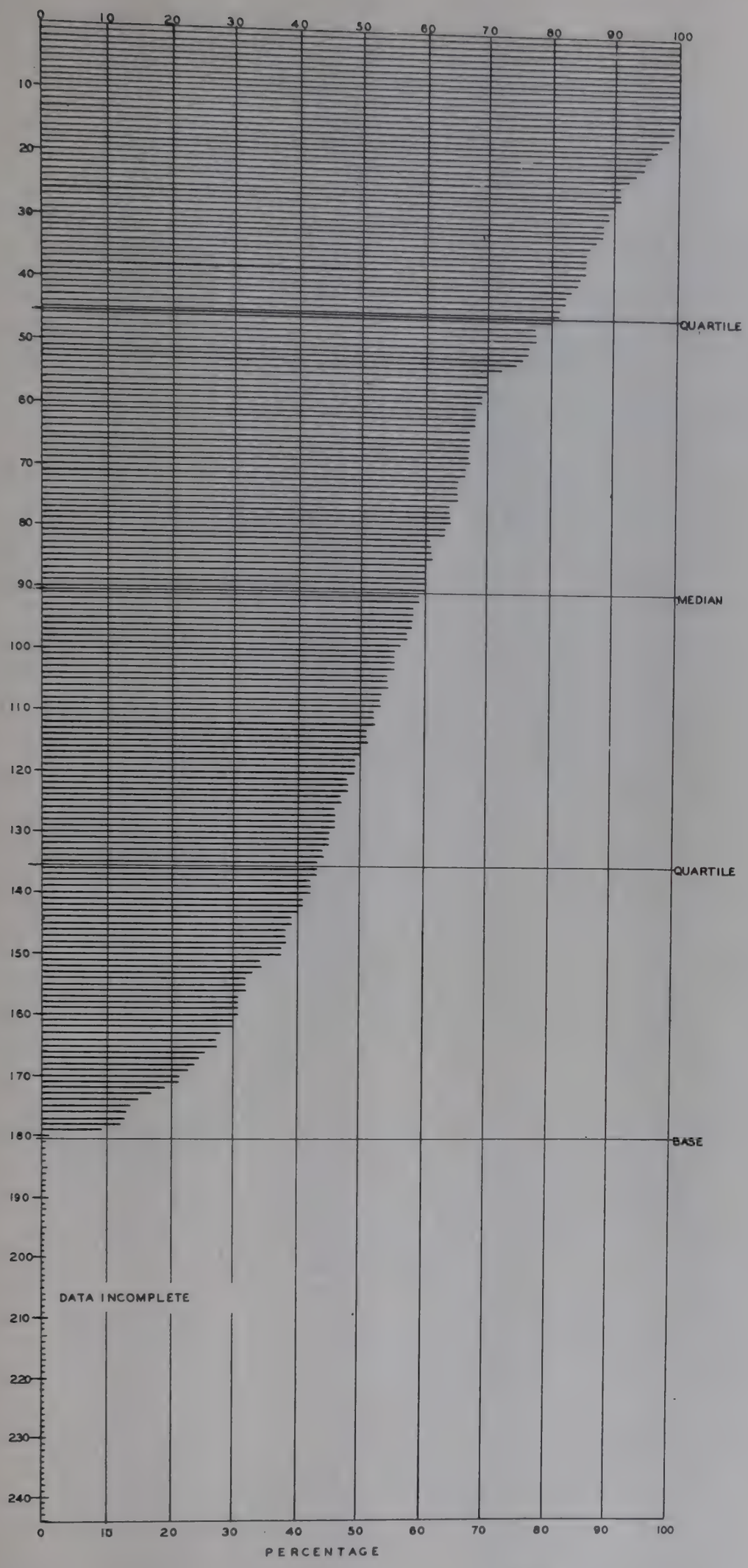
TUBERCULOSIS

ACTIVE CASES AT HOME

PERCENTAGE DUE TO LACK OF HOSPITAL FACILITIES

This chart depicts the proportion of active cases still living at home for the specific reason that there are no available hospital accommodations. About one-third of 177 communities reporting the facts have a clear-cut postwar construction program crying for attention. The number of places with this problem would probably be much greater if the 57 communities which have no available data on this subject were able to report the facts.





TUBERCULOSIS

CONTACTS OF REGISTER CASES

PERCENTAGE EXAMINED WITH X-RAY

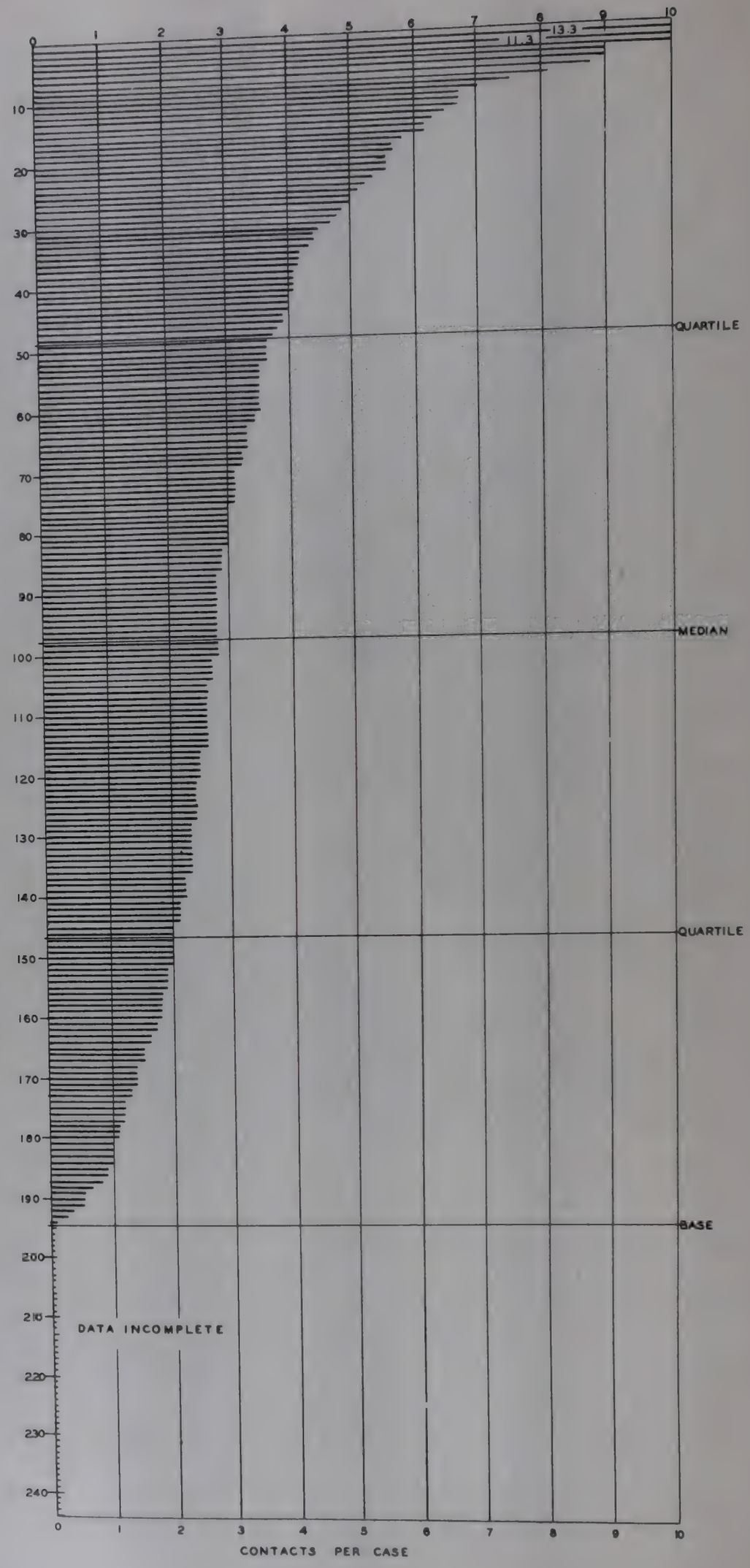
Follow-up and roentgenological examination of contacts is a vital part of a tuberculosis control program. The number of communities carrying out this part of the program with completeness is very small, only 13 in all. Lack of x-ray facilities, lack of nursing personnel for follow-up and lack of data all contribute in varying degrees to the shortcomings displayed in this chart. A surprising number of communities have no data to present on this subject.

The record is better in the smaller communities, those under 100,000 population, than in communities of more than 100,000. The respective medians are 61. and 44.

NEWLY REPORTED CASES

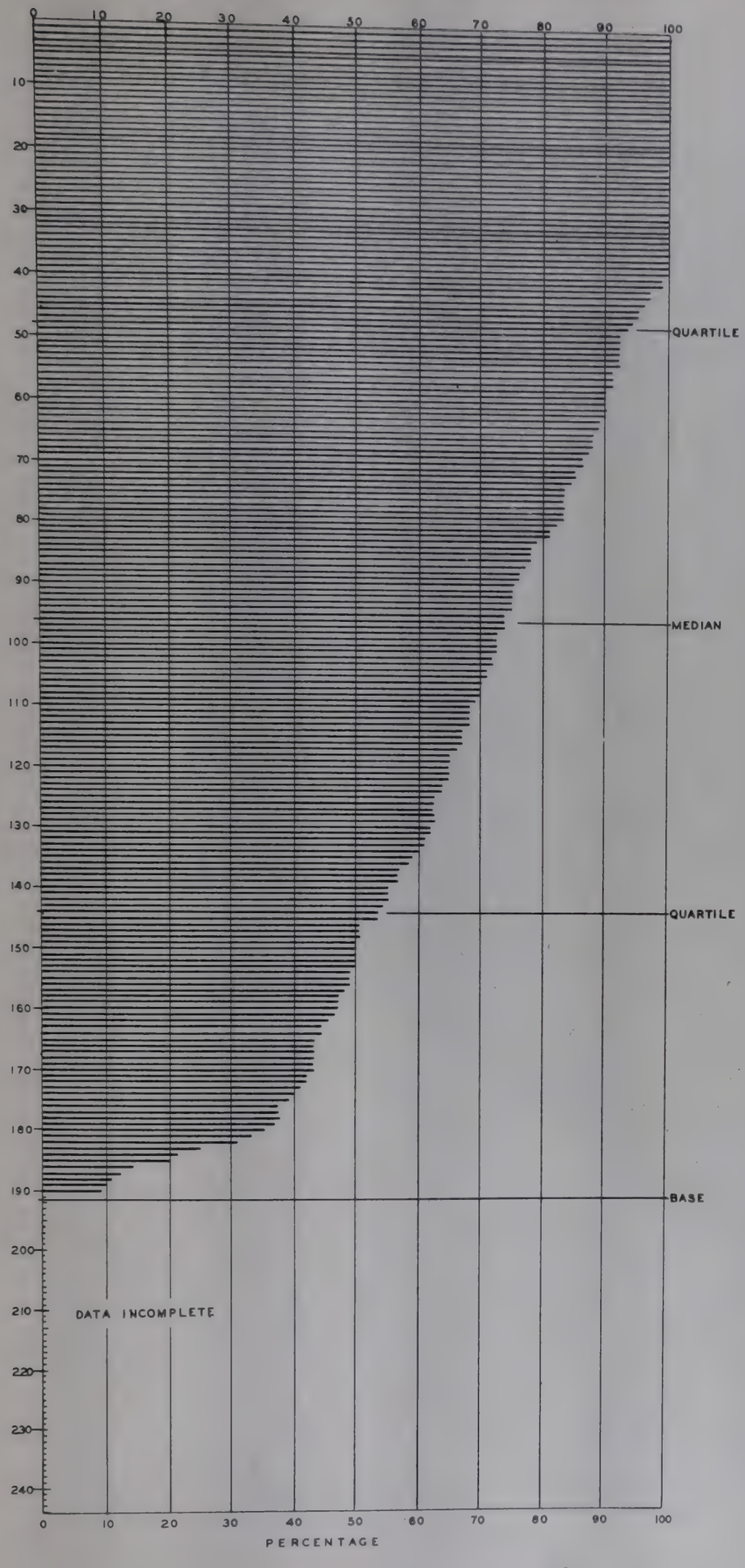
CONTACTS PER CASE REPORTED

The number of contacts for each case reported in the last year shows a median figure of 2.8. Evidently contacts are not being identified in many of the communities in the lower quarter of the chart. Contacts of active cases make up the logical group to be carefully examined in the search for additional cases.



CONTACTS OF NEWLY REPORTED CASES

PERCENTAGE EXAMINED



This is a much more favorable looking chart than several others in this section. The contacts to the current year's cases have received more attention than contacts to cases on the register in previous years. Once the contacts are identified their examination with x-ray follows with considerable completeness in many communities. In fact the median figure is 74 per cent. Much more thorough follow-up is still needed however in the lower ranges of the chart.

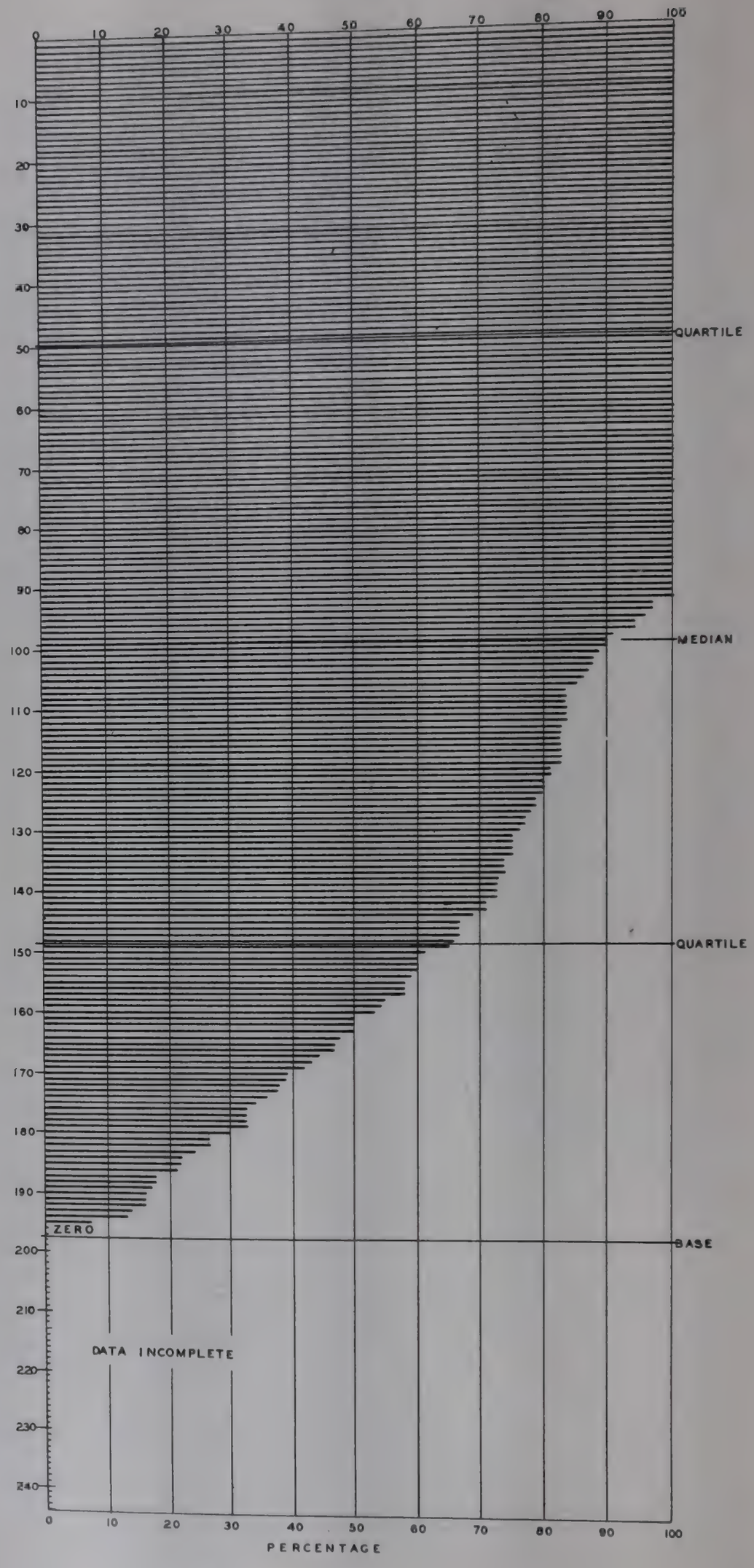
The median for the larger communities is 74., as compared with 64. for the smaller areas.

TUBERCULOSIS

NEWLY REPORTED CASES

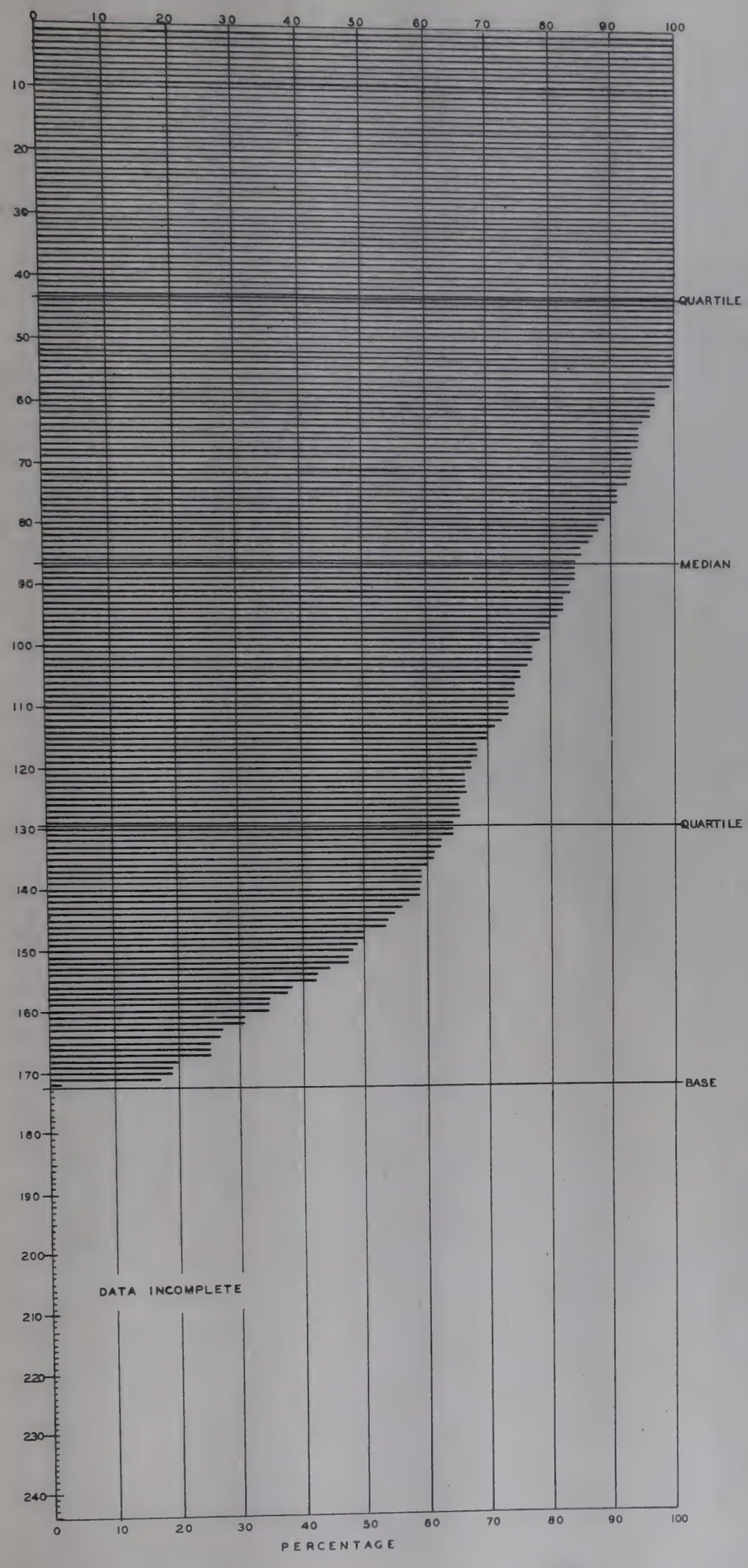
PERCENTAGE VISITED BY NURSE WITHIN ONE MONTH

Prompt nursing visitation of the newly reported case is the practice of about half of the communities reporting these facts. This is a well done part of the tuberculosis control program. Failure to visit cases promptly may be due to lack of nursing staff or to a lack of realization of the importance of giving these cases early attention.



REGISTER CASES

PERCENTAGE OF HOMES VISITED BY NURSE IN THE YEAR



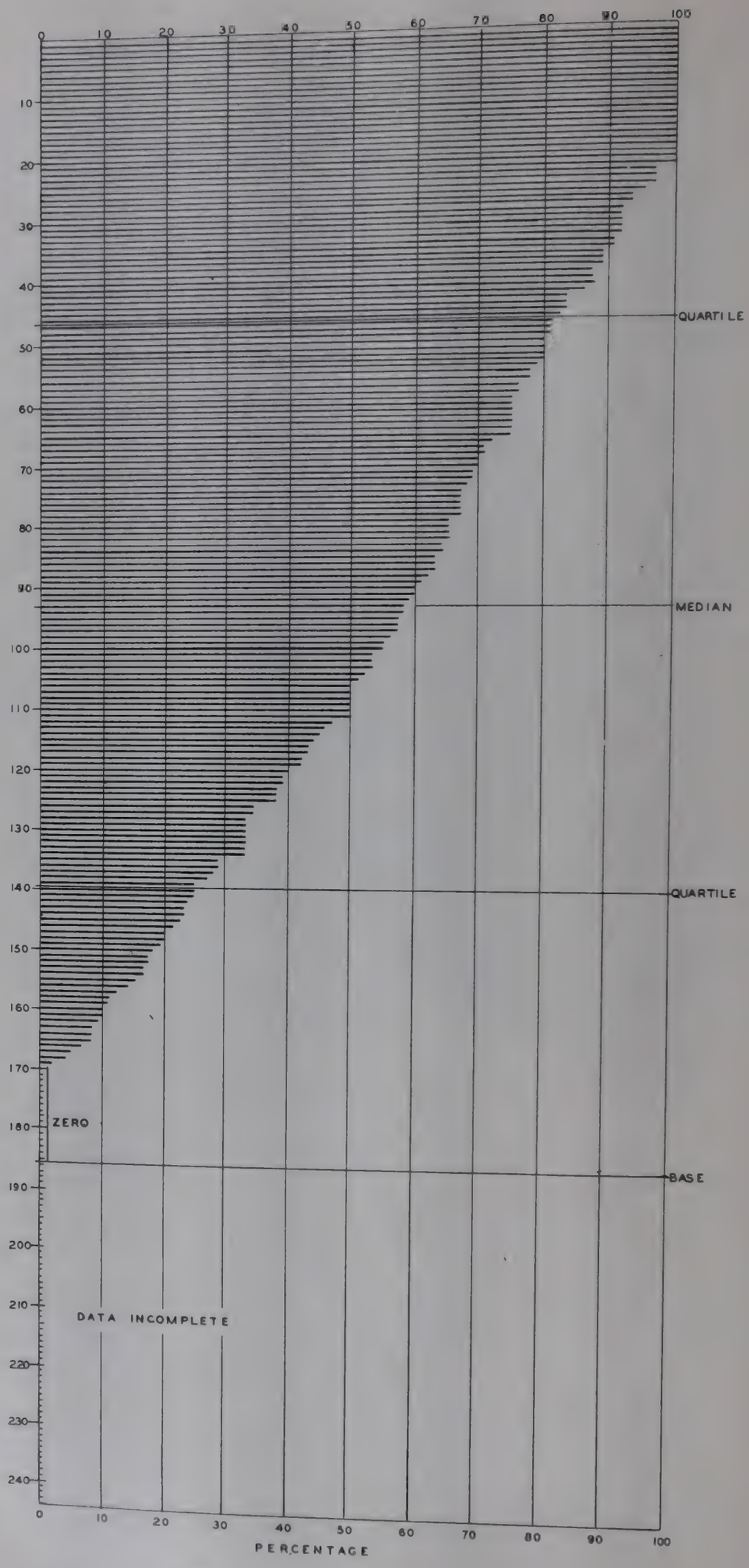
It is worthwhile to visit the homes of all cases on the register at least once a year, even though the case is in the hospital. This is necessary to learn of possible new cases, to find out if family circumstances have changed materially, and also to determine whether the family has moved to another location. Such visitation is one means of keeping the facts on the register up to date. Only a third of the communities reporting follow this practice systematically. A surprisingly large number of communities have no data on this point. These data are intended to include visits by all voluntary agencies and not just health department nurses alone.

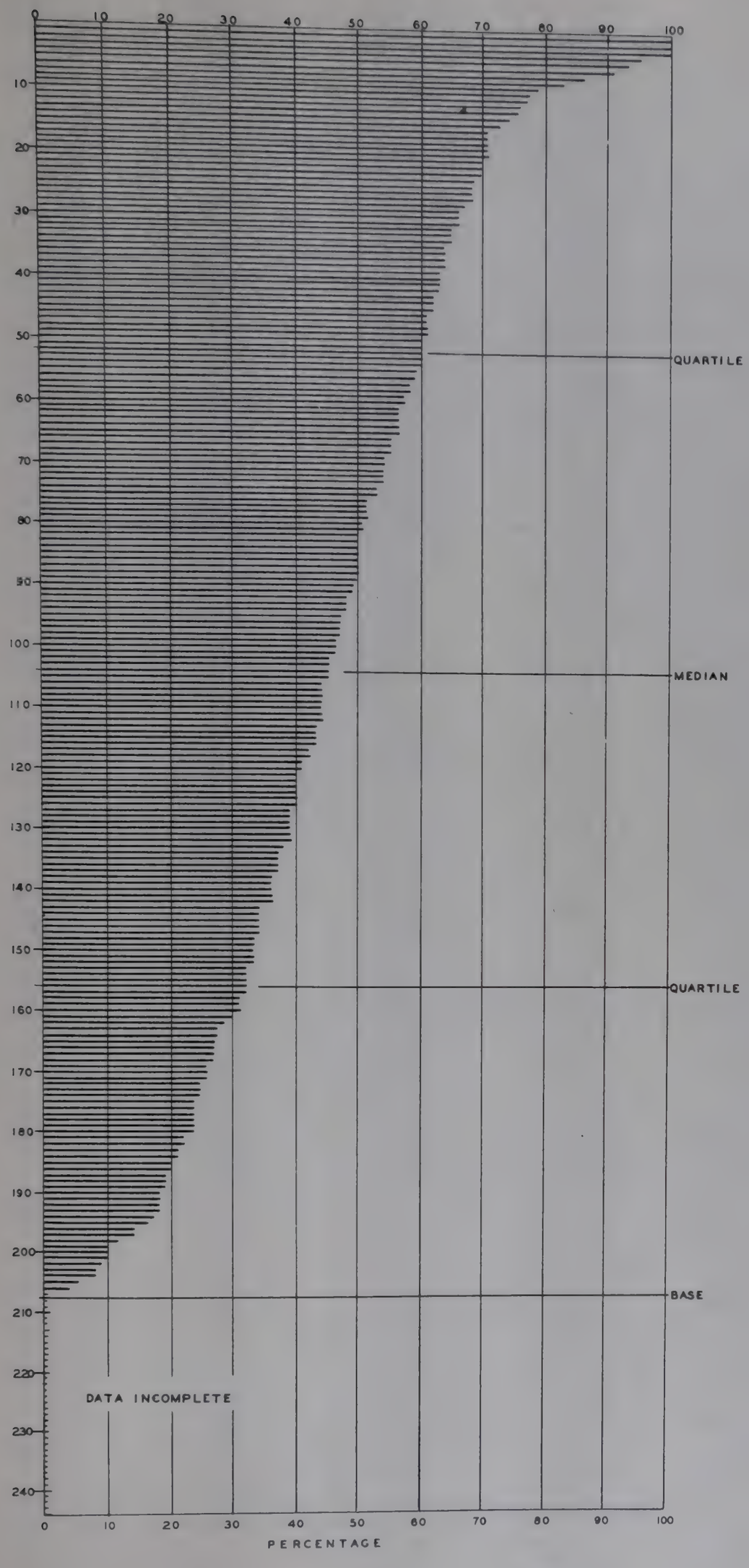
TUBERCULOSIS

ACTIVE CASES REPORTED BEFORE DEATH

PERCENTAGE HOSPITALIZED WITHIN TWO MONTHS OF REPORT

This is another angle on the hospitalization picture. Very few communities have succeeded in getting their active cases into the hospital with a minimum of delay. The median performance is less than 60 per cent of cases hospitalized within two months. Lack of hospital beds and unsuccessful efforts in inducing patients to accept hospitalization both contribute to the shortcomings in the lower part of the chart.





SYPHILIS

CASES REPORTED

PERCENTAGE IN EARLY AND EARLY LATENT STAGES

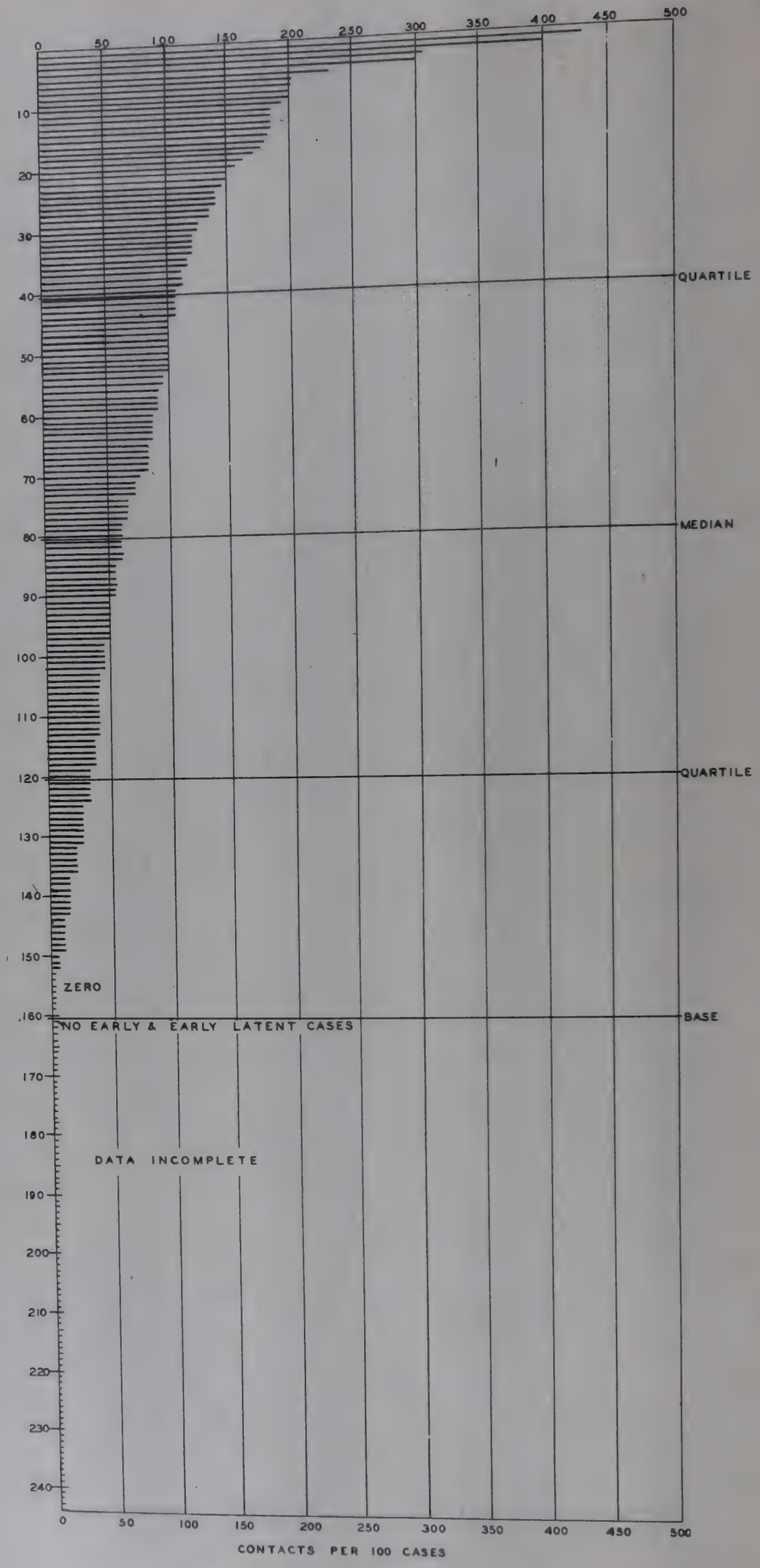
On the average about 45 per cent of the total syphilis cases reported by this group of communities are in the earlier stages of the disease. The health department's primary objective is with the early infectious case. The bad after-effects of syphilis can be prevented by finding the case early and instituting prompt treatment. It would appear that far more effort should be expended in locating the early cases.

SYPHILIS

EARLY AND EARLY LATENT CASES

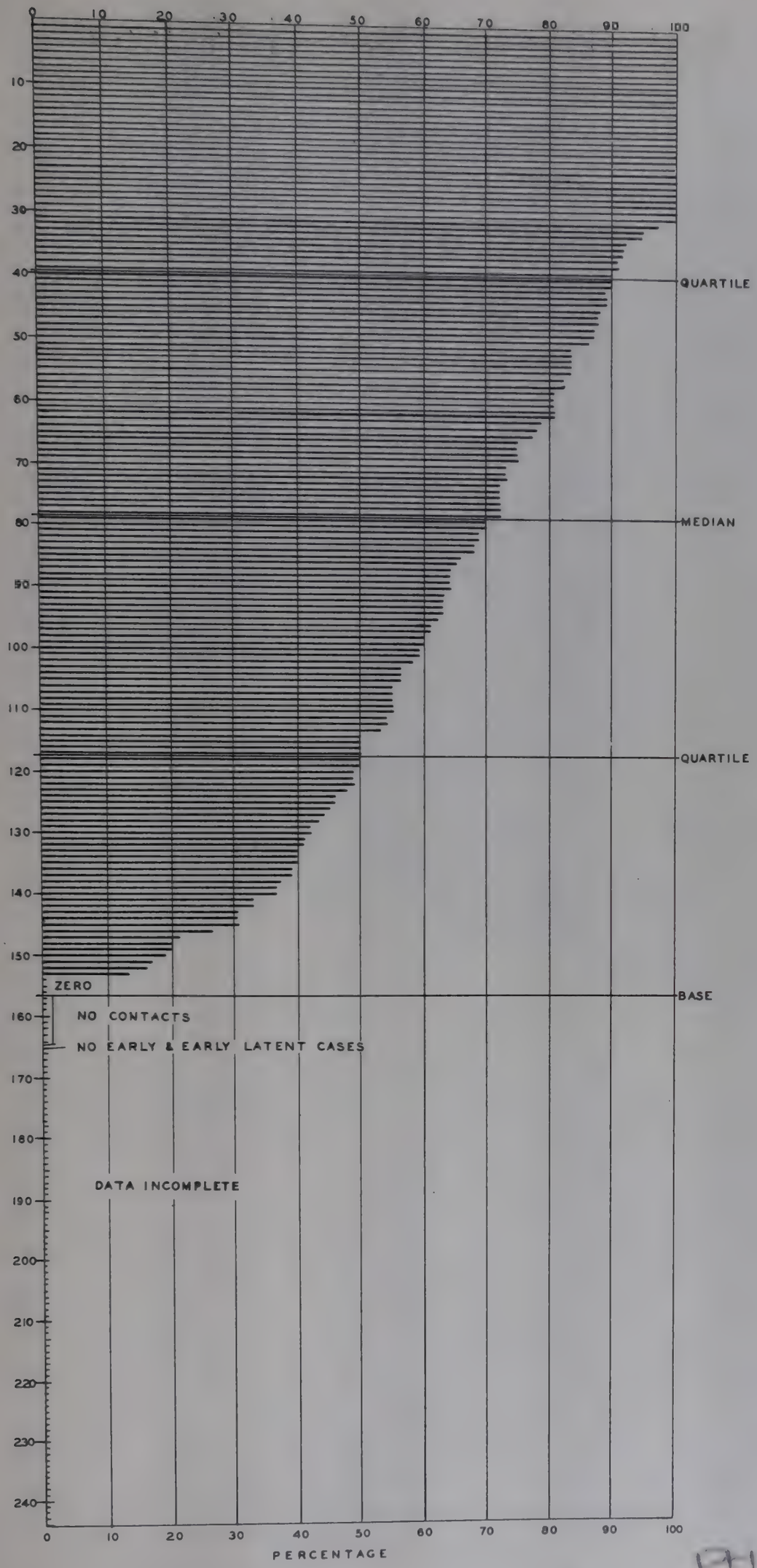
SEX CONTACTS REPORTED PER 100 CASES

Syphilis control programs should place more emphasis on the finding of contacts to infectious and potentially infectious cases of syphilis than on the finding of contacts to cases reported in other stages of the disease. The reporting of at least one contact for each early and early latent case reported is achieved by less than one fourth of the communities. Reporting falls off badly in the lower half of the chart. Of the 243 communities submitting schedules there were 82 which had no available data on this point.



SEX CONTACTS OF EARLY AND EARLY LATENT CASES

PERCENTAGE EXAMINED



The degree of success in follow-up of contacts is illustrated in this chart. Many contacts are reported who never appear for examination. While the median is 71 per cent, the figures for communities in the lower half of the chart fall off steadily to zero in three communities. A large number of communities have no available data of this nature.

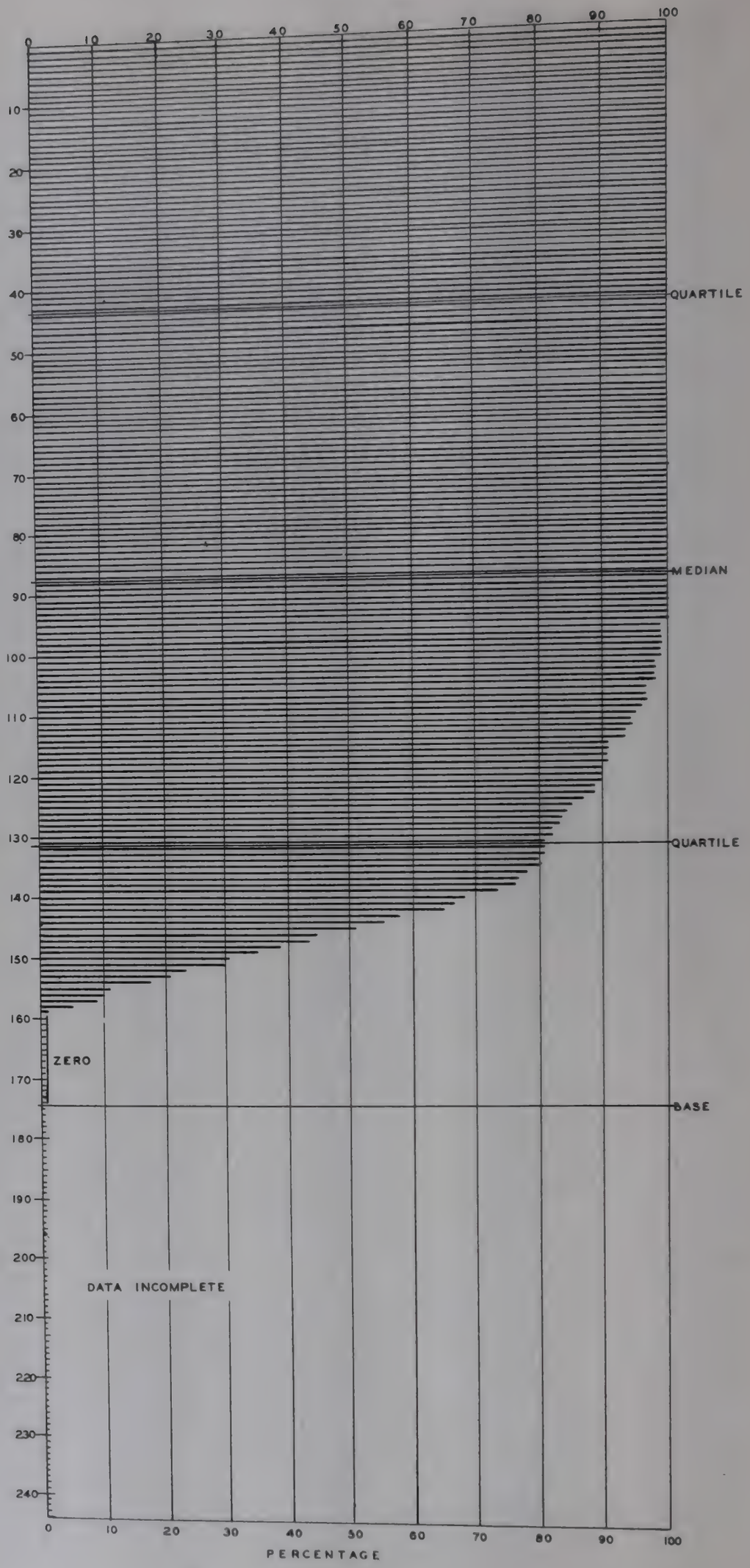
The larger communities have a lesser proportion of contacts examined, the median being 57. as compared with 73. for the smaller areas.

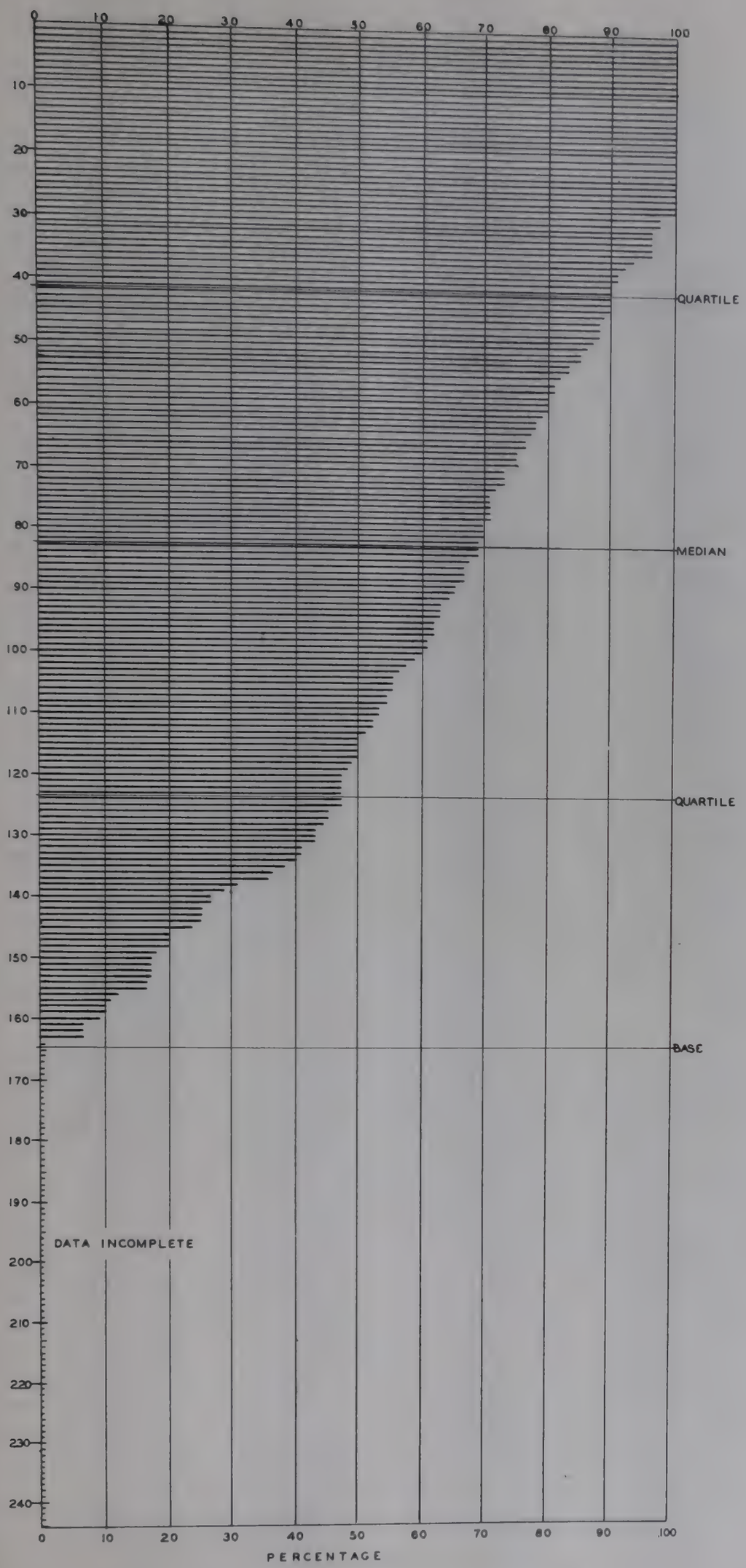
SYPHILIS

CASES REPORTED

PERCENTAGE REPORTED BY NAME

This chart furnishes convincing evidence of increasing open-mindedness in dealing with the syphilis problem. More than half of the reporting communities are following the practice of reporting cases by name the same as is done with any other communicable disease. In the lower section of the chart, oversensitiveness still prevails and cases continue to be reported chiefly by initials or by an identifying numeral.





EARLY AND EARLY LATENT CASES UNDER TREATMENT AT BEGINNING OF YEAR

PERCENTAGE ADEQUATELY TREATED

While the Evaluation Schedule for several years has defined adequate treatment mainly in terms of at least 20 arsenicals and 20 heavy metals, or the equivalent, in the course of a year, the newer methods of rapid treatment have shortened the time factor very materially. The communities represented in the 1943 indices are not identical with the representation this year. Therefore it may or may not be significant that the median figure for those completing treatment this year is 69 per cent as compared with 60 per cent last year. The proportion of cases completing treatment falls off badly in the lower quarter of the chart.

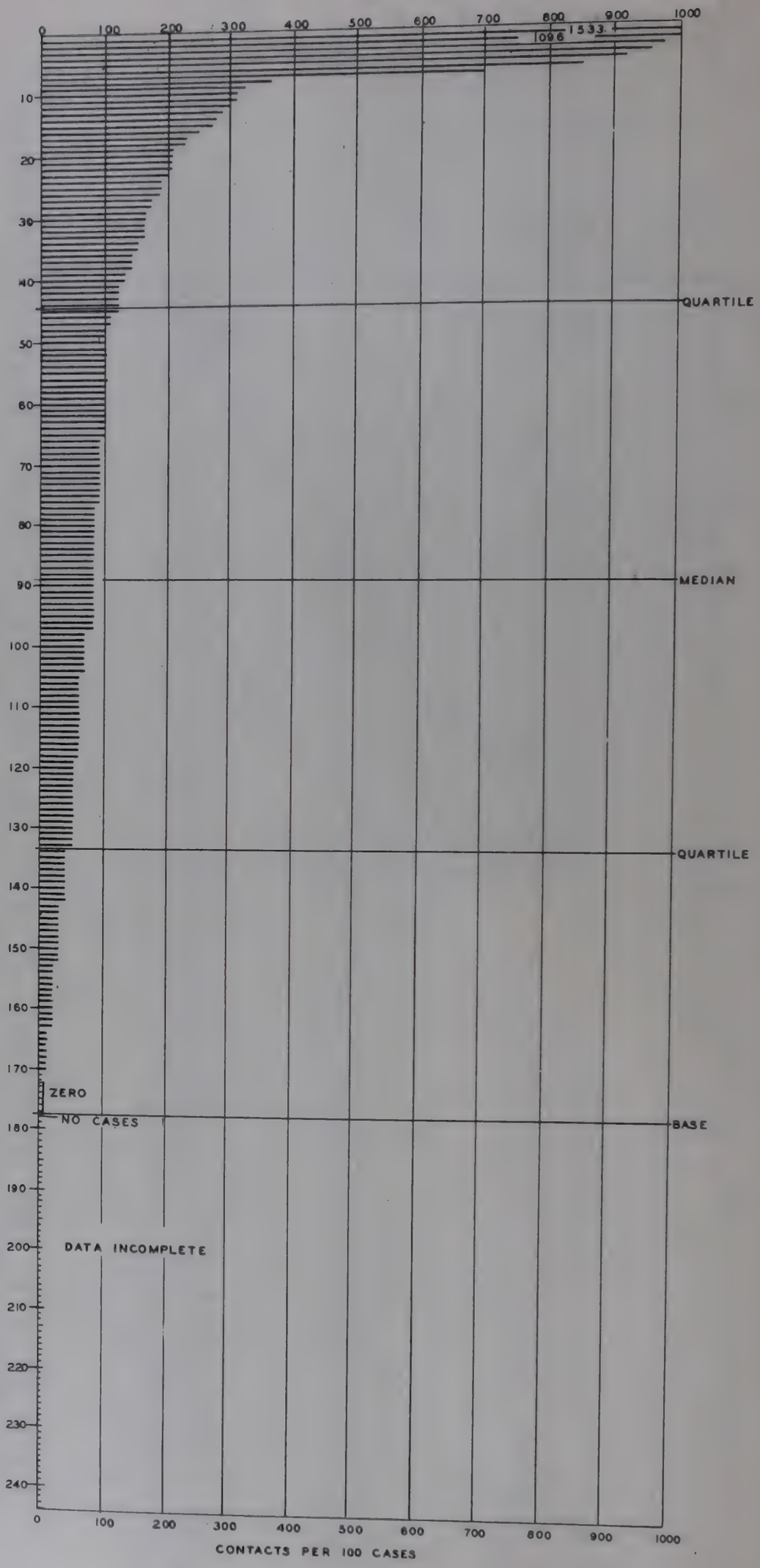
GONORRHEA

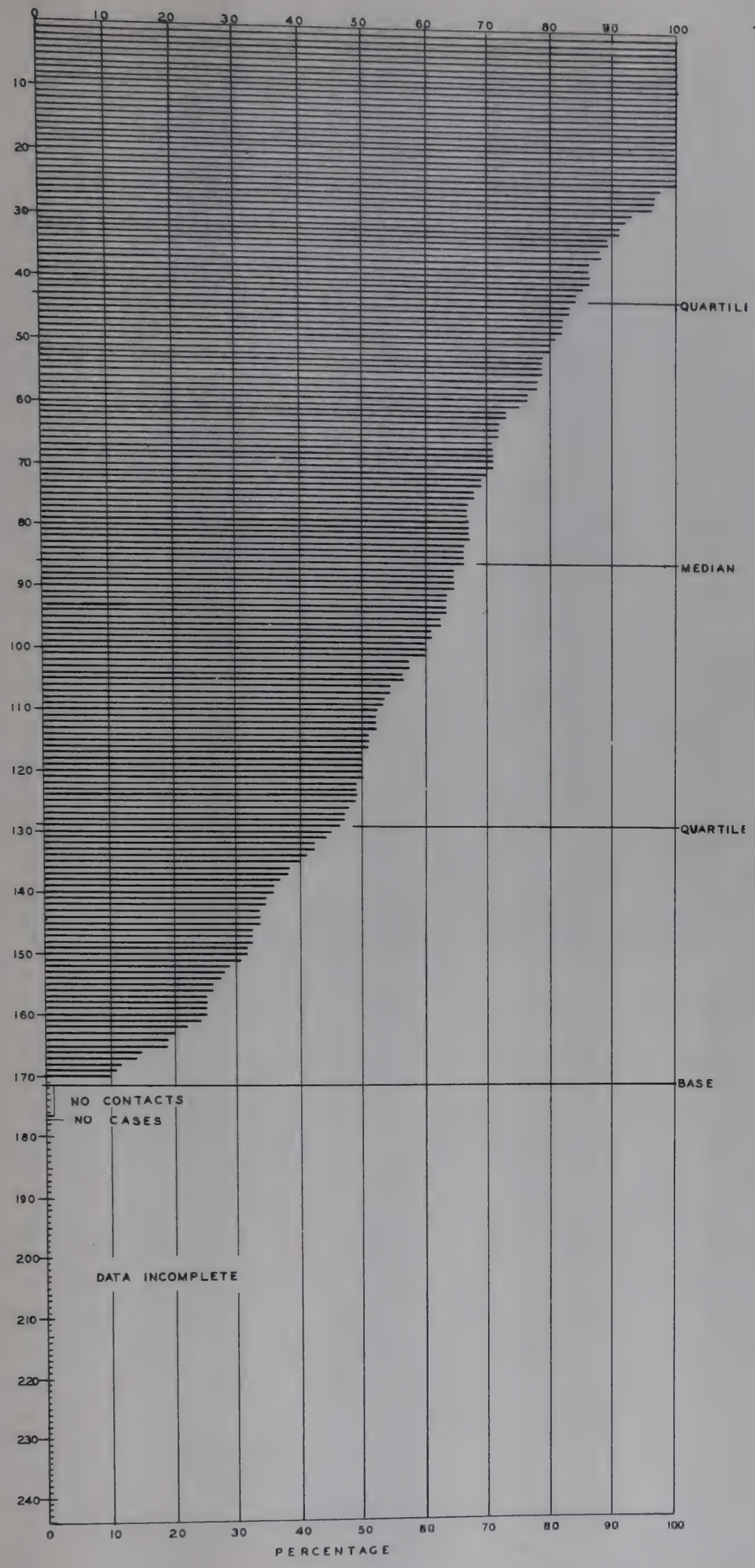
CASES REPORTED

SEX CONTACTS REPORTED PER 100 CASES

More contacts are reported for gonorrhea cases than for early cases of syphilis, judging by the medians. Only about one fourth of the communities however, report at least one contact per case. Five communities report no contacts and one reports no case of gonorrhea.

The larger areas report more contacts, the median being 95. as against 77. for the smaller areas (those under 100,000 population).





GONORRHEA

SEX CONTACTS REPORTED

PERCENTAGE EXAMINED

A median figure of 66 per cent is indicated. This number is somewhat less than for the contacts of early cases of syphilis. Many contacts escape examination. This is all part of the follow-up program. It is such inadequacies in the program that warrant the addition of special investigators to follow up contacts more assiduously.

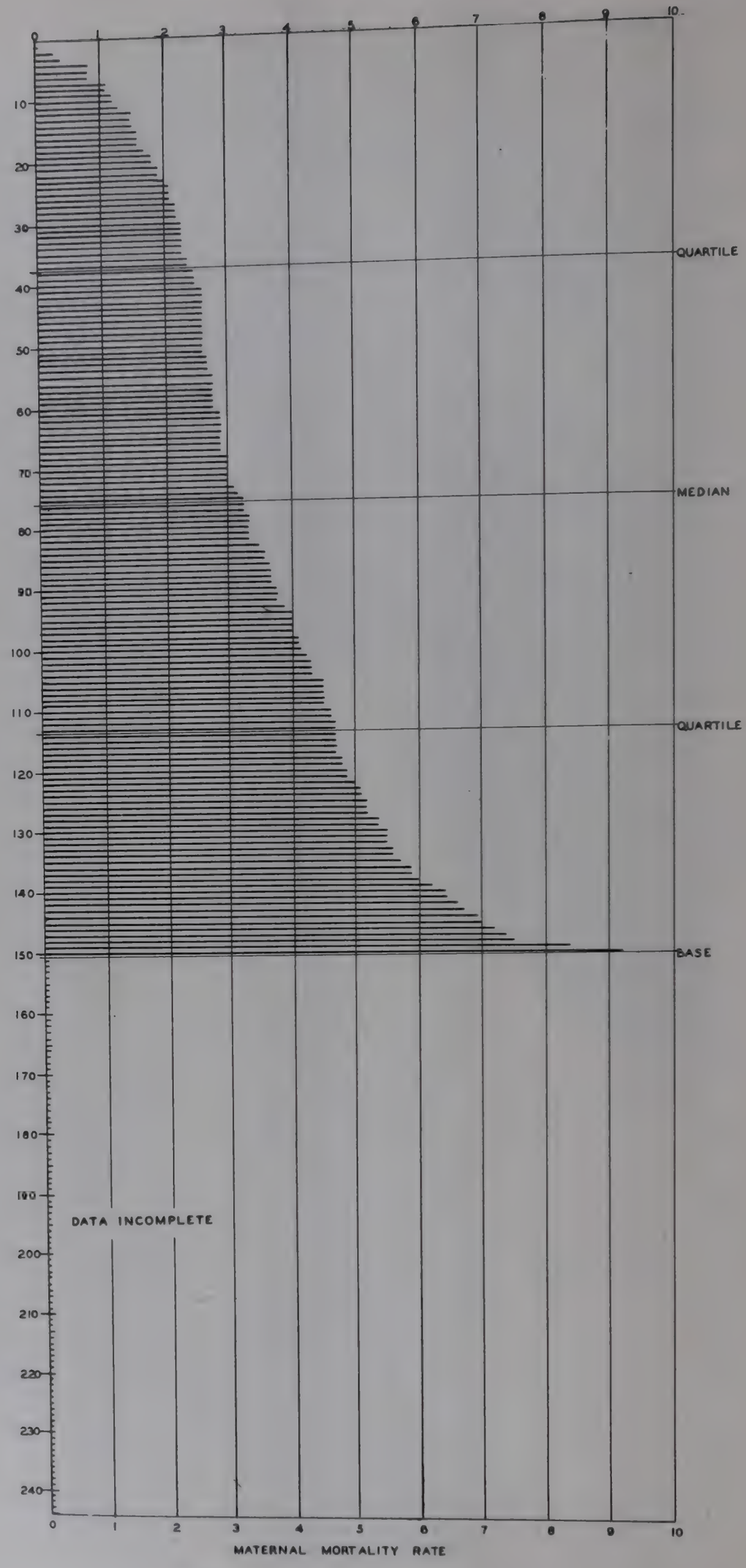
A greater proportion of contacts is examined in the smaller areas, the median being 67. For the communities over 100,000 population the median is 52.

PUERPERAL DEATHS PER 1000 TOTAL BIRTHS

TEN YEAR PERIOD

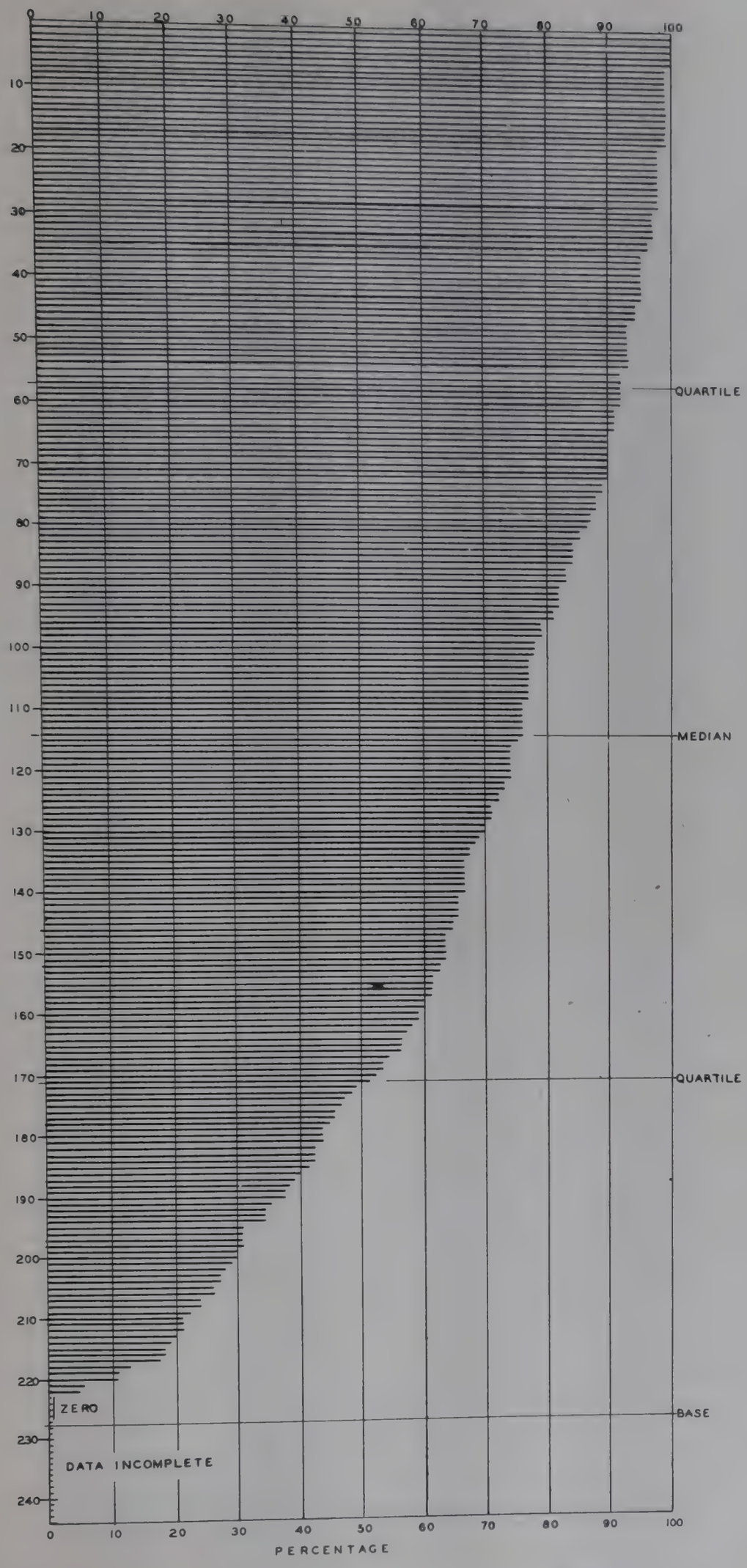
The median figure for the maternal mortality rate over a ten year period is 3.3. The ten year average, ending in 1943, for the registration states was 4.3. In 1943, the rate for the United States was 2.5.

There is wide variation in the rates of these communities, from zero to 9.2. No data were reported for the ten year period from 93 communities. There is still much to be done in preventing maternal deaths.



TOTAL BIRTHS

PERCENTAGE IN HOSPITAL

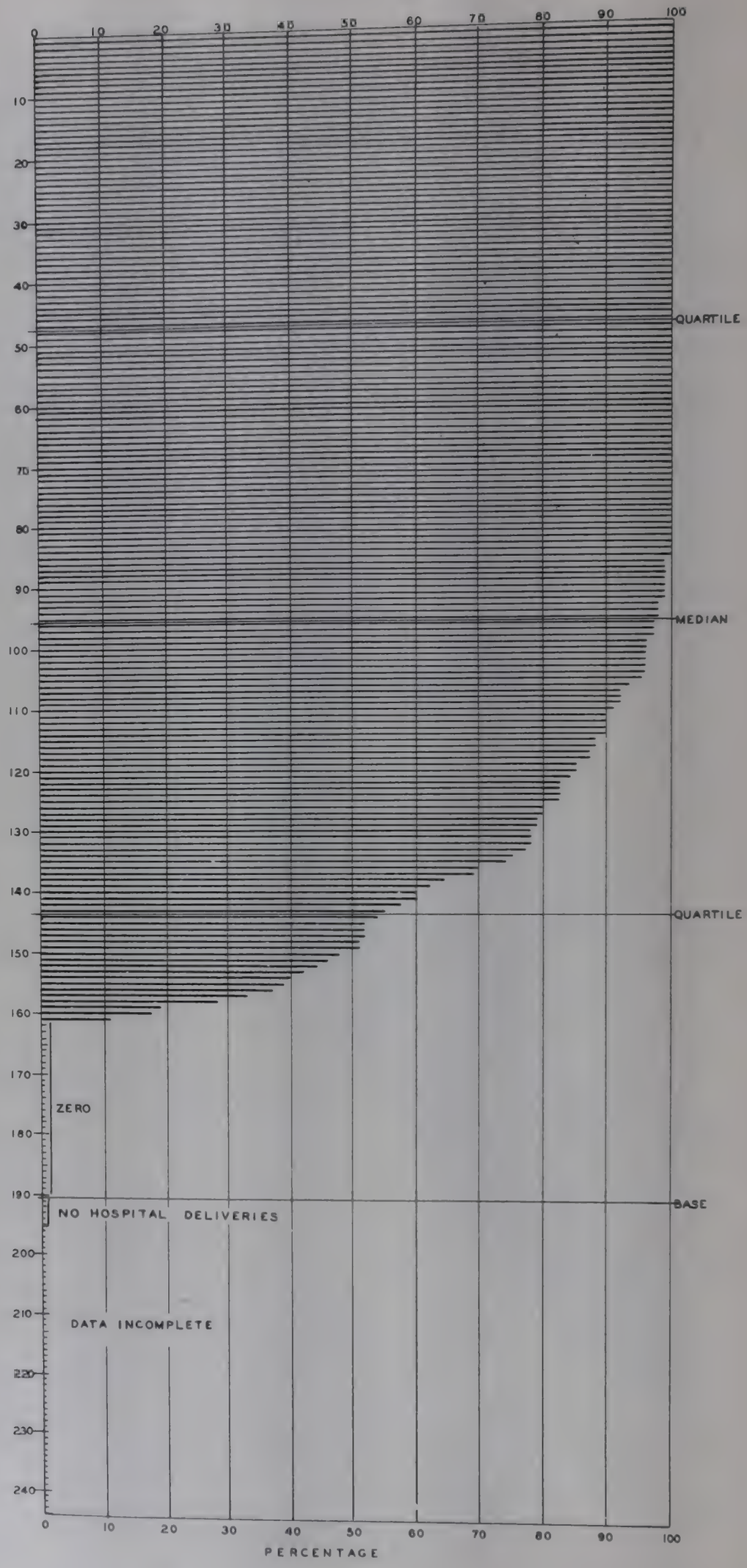


The major proportion of births occur in hospitals. The median for the 227 communities reporting is 76 per cent. In five areas at the top of the chart all births are in hospitals. At the bottom of the chart there are also five areas having no births in hospitals. Large communities report a median of 88., while areas under 100,000 report a median of 71.

HOSPITAL BIRTHS

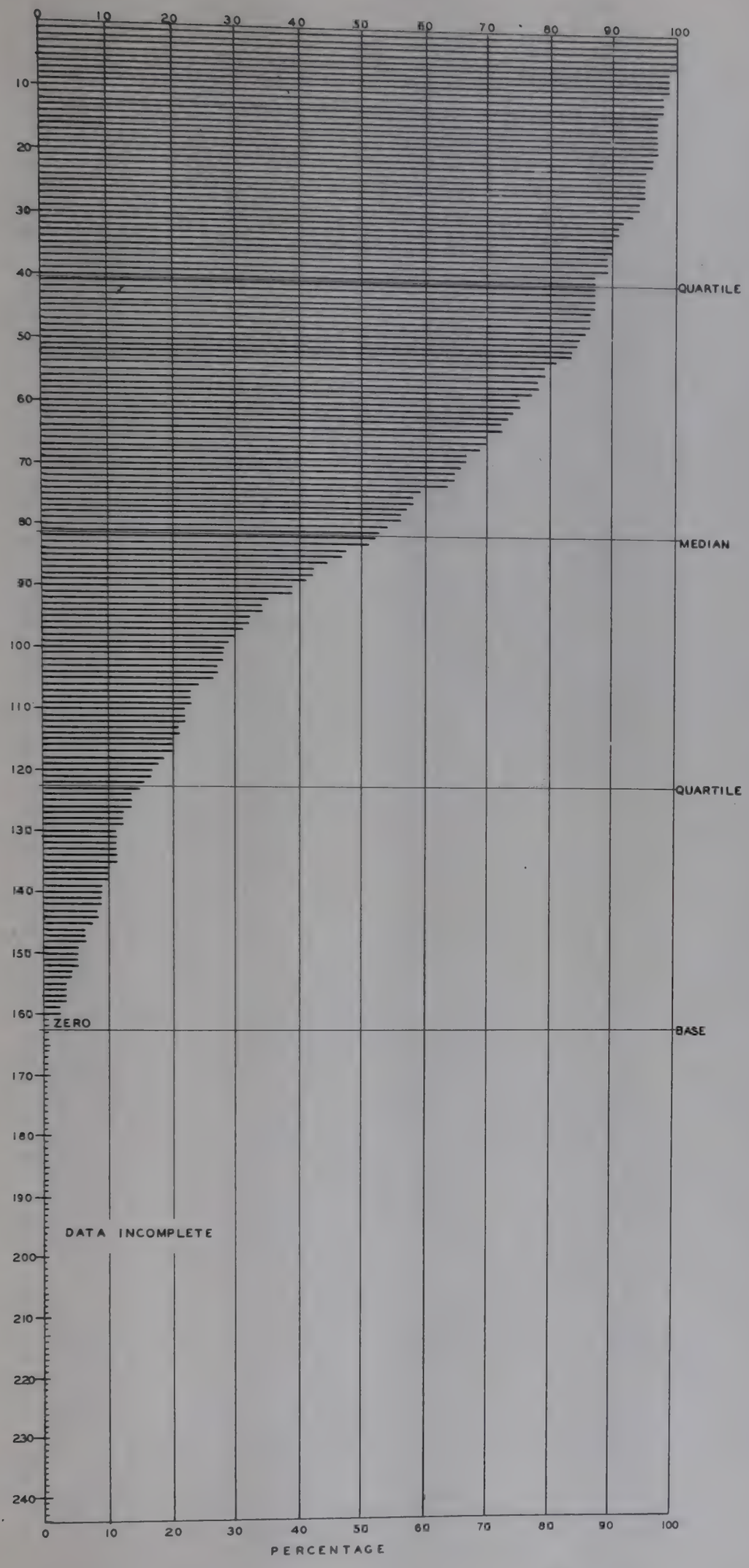
PERCENTAGE IN HOSPITALS WHOSE OBSTETRICAL DEPARTMENTS MEET MINIMUM STANDARDS OF AMERICAN COLLEGE OF SURGEONS

Nearly half the reporting communities show all their births taking place in hospitals with approved obstetrical departments. Below the median, however, there is a clearly outlined problem facing many communities in the years immediately ahead. No approved facilities are available to the mothers of 29 communities. Beyond these are a substantial number of communities which have not determined this necessary information.



WOMEN DELIVERED

PERCENTAGE KNOWN TO HAVE HAD ANTEPARTUM MEDICAL SUPERVISION

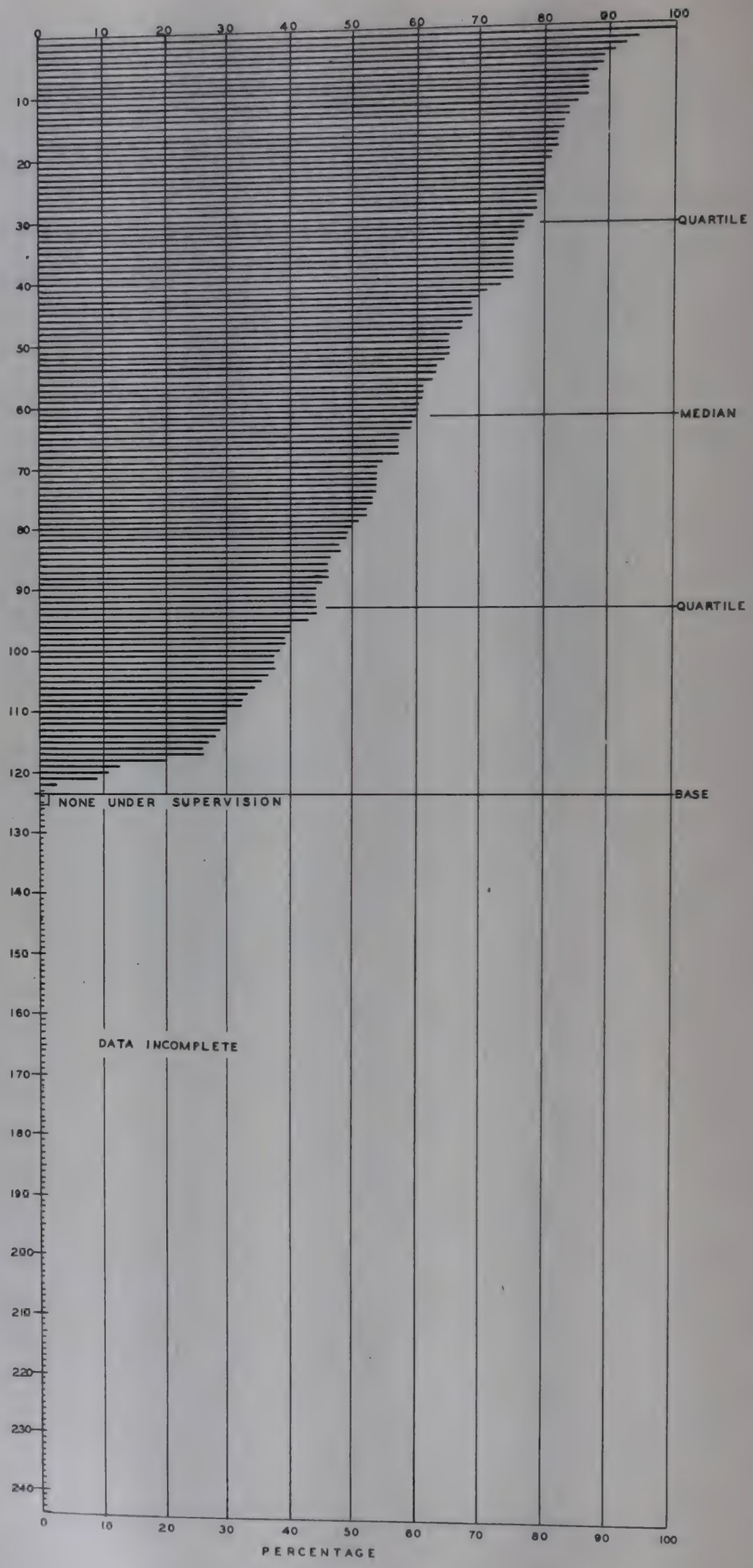


These data are limited to those women for whom the health department has information. Admittedly this is an incomplete picture for some communities. In protecting the health of the community it would seem that a health department should know whether expectant mothers are receiving antepartum medical supervision. Some departments have added items to their birth certificates for reporting such service and thus are able to gather information on all maternity cases. A large number of communities have no information at all on this question.

WOMEN KNOWN TO HAVE BEEN UNDER ANTEPARTUM MEDICAL SUPERVISION

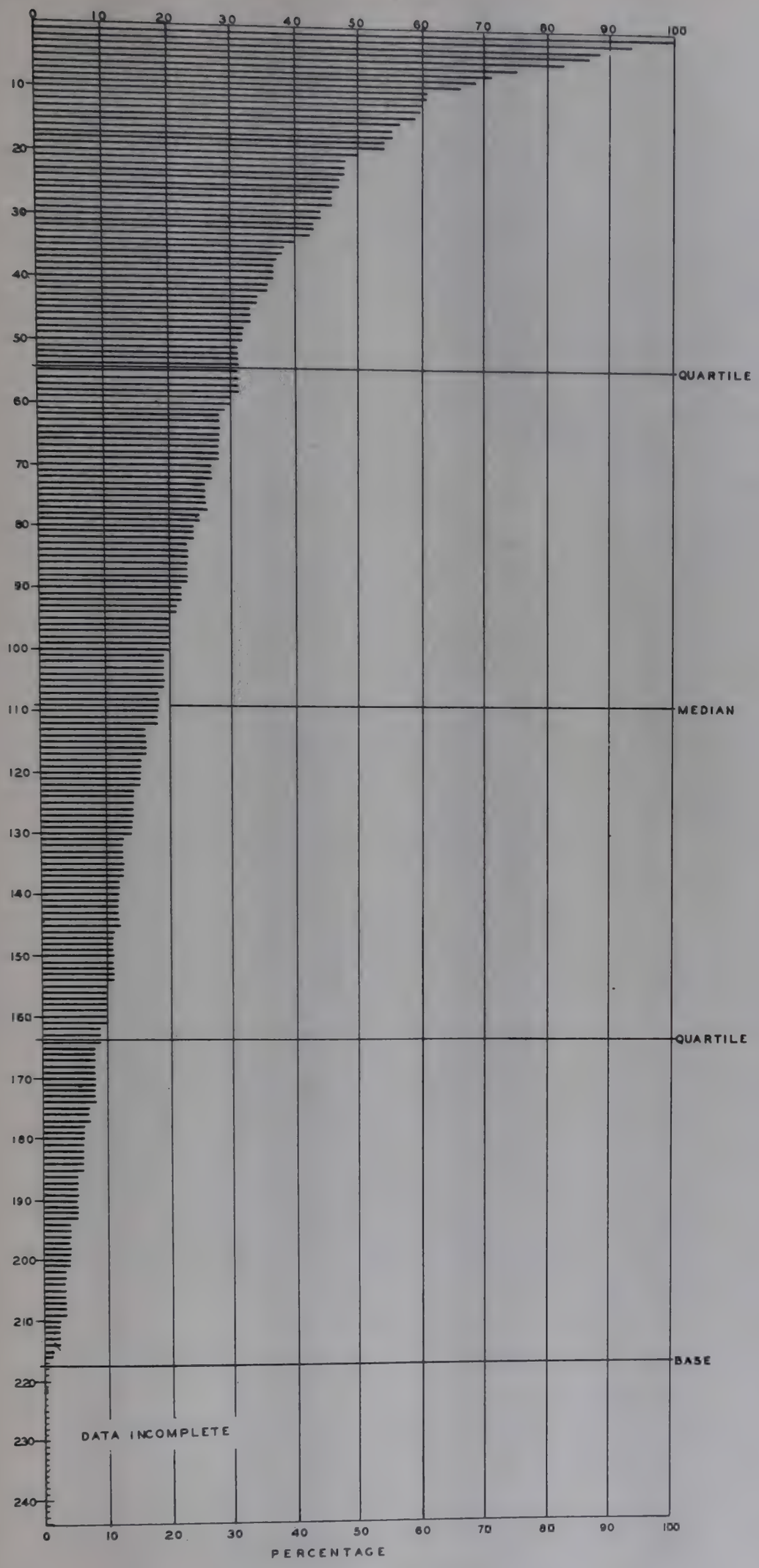
PERCENTAGE UNDER SUPERVISION BEFORE SIXTH MONTH

Antepartum care to be effective should begin prior to the sixth month of pregnancy. Less is known about this important matter than whether expectant mothers are under medical supervision at any time before delivery. These are important facts that require inquiries and statistical tabulation. With the scarcity of physicians and the lack of personnel in health departments during these war years one can understand that some activities have had to be omitted in favor of more pressing duties. However, with the advent of peace, the acquiring of this information ought to be undertaken seriously.



WOMEN DELIVERED

PERCENTAGE UNDER ANTEPARTUM NURSING SUPERVISION

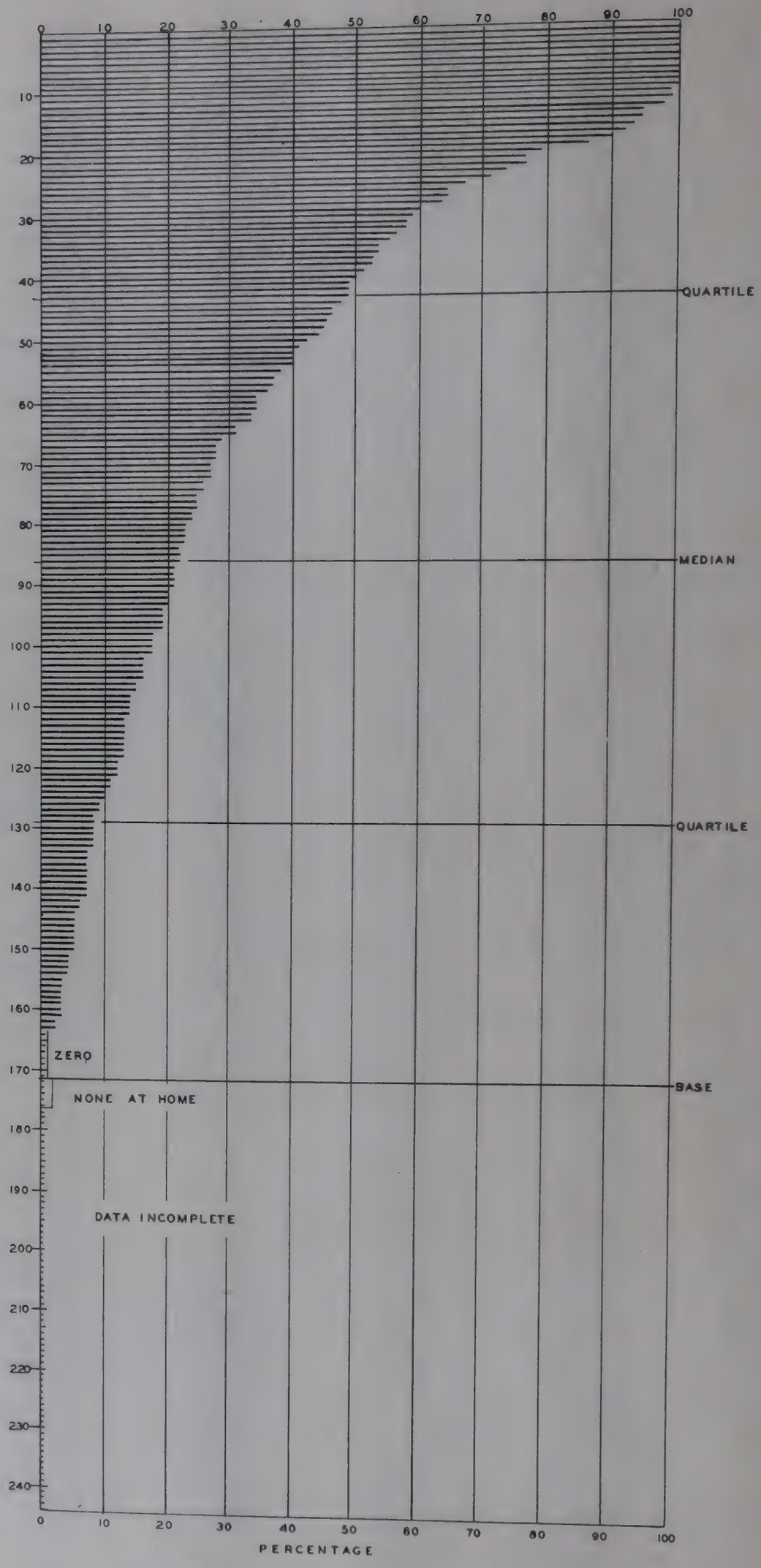


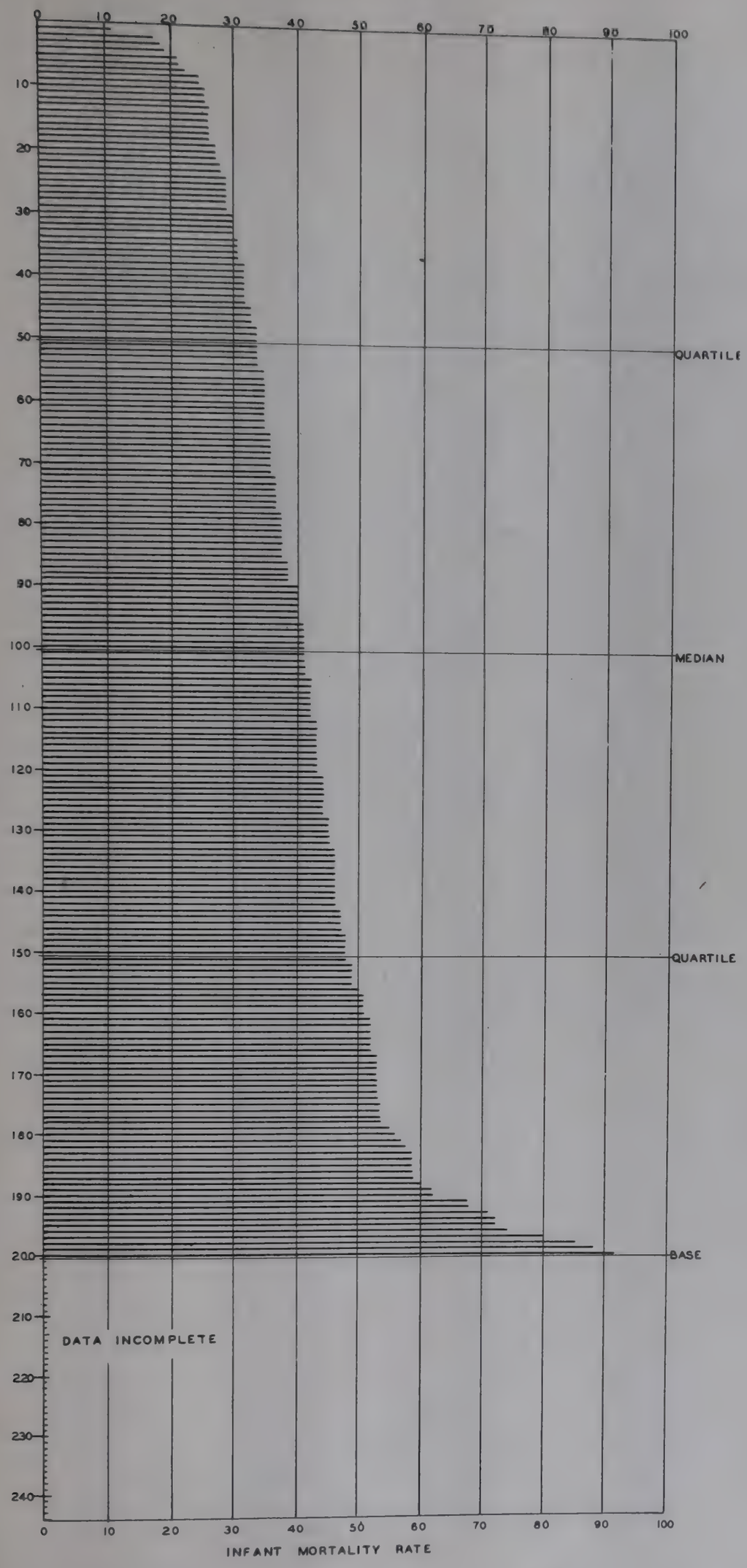
Because nursing service is usually given by some organization—health department and voluntary agencies—these records are more complete. Only 26 communities were unable to provide information. The proportion of expectant mothers receiving antepartum nursing supervision is meager, the median figure being only 18 per cent. It is to be hoped that service to primiparas and special groups where the need is greatest is being given preference if a choice has to be made.

WOMEN DELIVERED AT HOME

PERCENTAGE KNOWN TO HAVE HAD POSTPARTUM NURSING SUPERVISION

The median tells us that only 22 per cent of women delivered at home have received postpartum nursing supervision. This is a poorer showing than last year when the median figure was 28 per cent. Eight communities report no postpartum nursing service for women delivered at home. All too many communities have no information to give on this subject. These data include visits of all agencies, public and voluntary.





INFANT HEALTH

DEATHS UNDER ONE YEAR OF AGE PER 1,000 LIVE BIRTHS

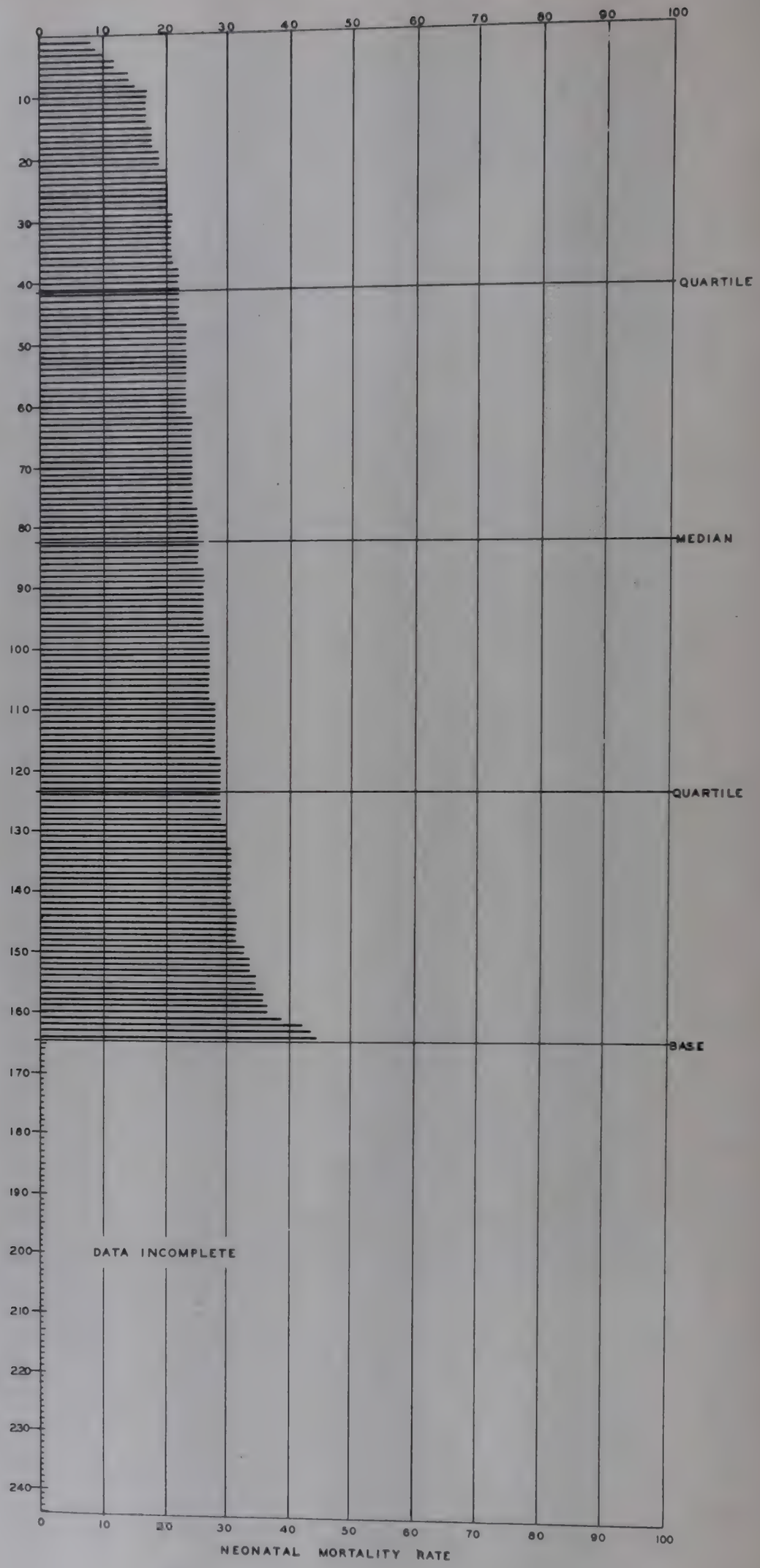
FIVE YEAR PERIOD

The median figure for infant mortality (over the last five years) is 41.3 deaths under one year of age per 1,000 live births. The average rate for the United States in the five year period ending in 1943 was 44.2. The range in rates in this group of communities is wide, from 10.7 to 92.0. If babies could choose their place of birth, the communities at the top of the chart would offer superior attractions.

DEATHS UNDER ONE MONTH OF AGE PER 1,000 LIVE BIRTHS

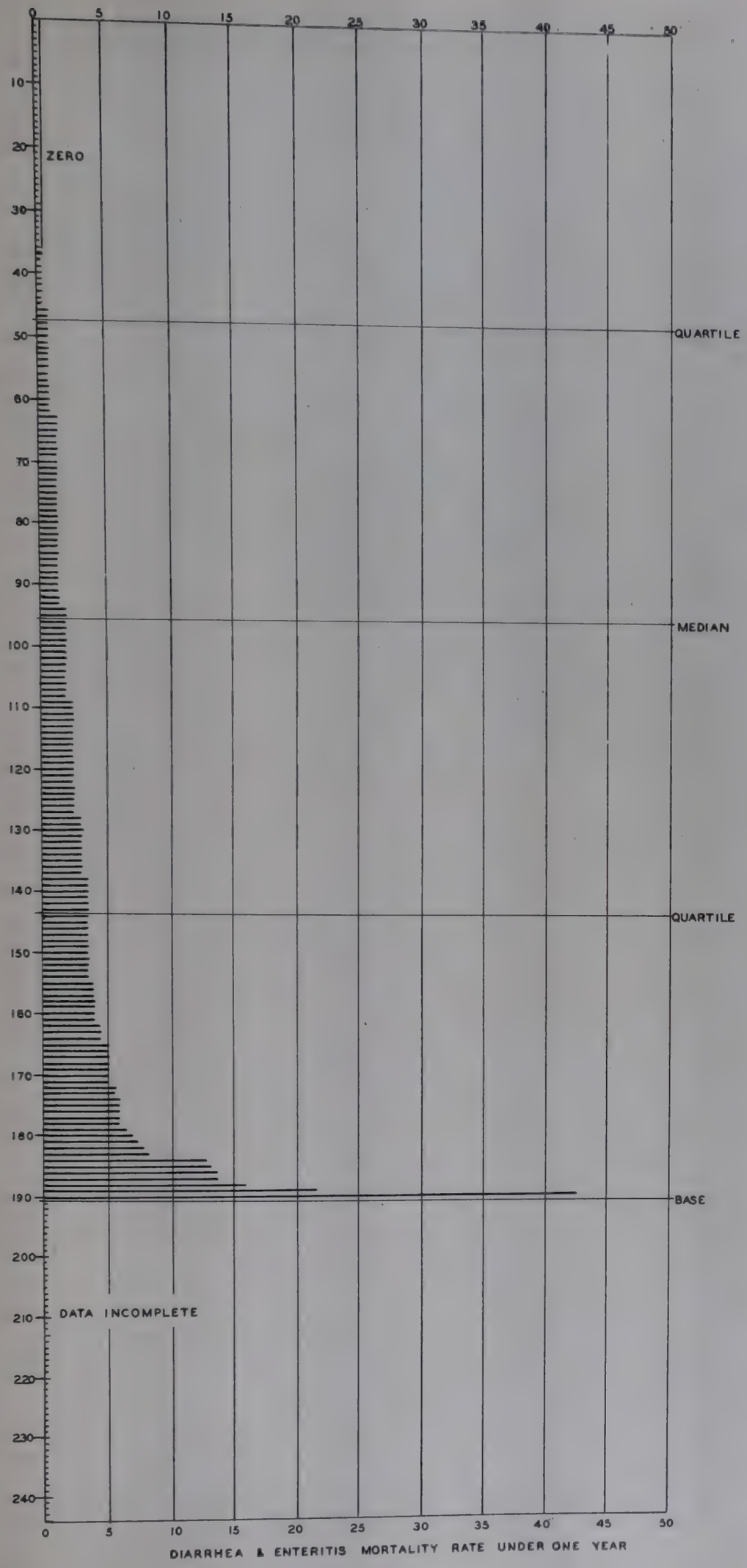
FIVE YEAR PERIOD

The median figure for the last five years indicates that of every 1,000 babies born alive during the year, 25 died during the first month of life. The rates for more than half the communities reporting lie between 20 and 30. Early antepartum care of mothers and good obstetrical service are the forces to be relied on largely in reducing mortality in the first month of life.



DIARRHEA AND ENTERITIS DEATHS UNDER ONE YEAR OF AGE PER 1,000 LIVE BIRTHS

TWO YEAR PERIOD

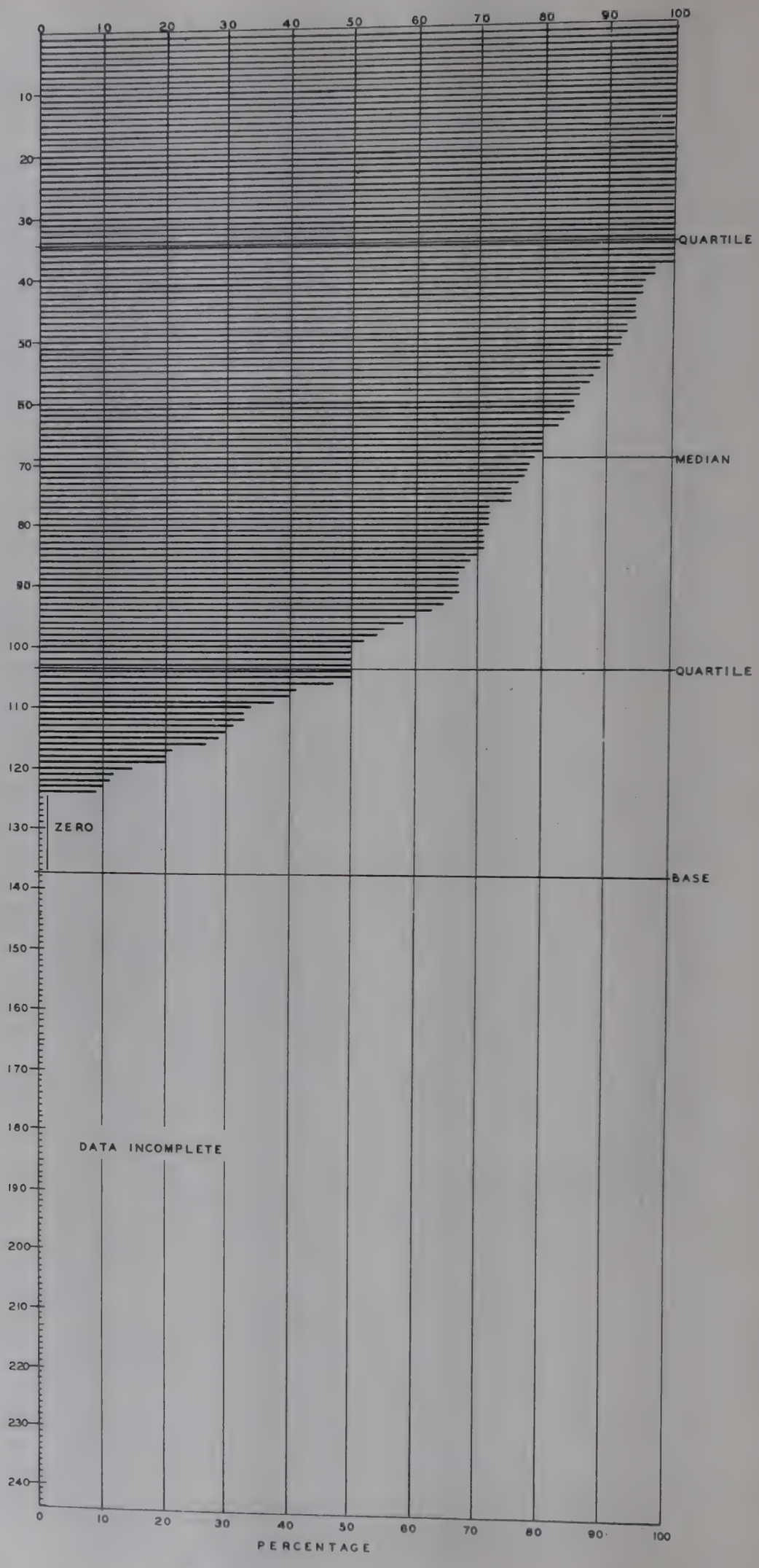


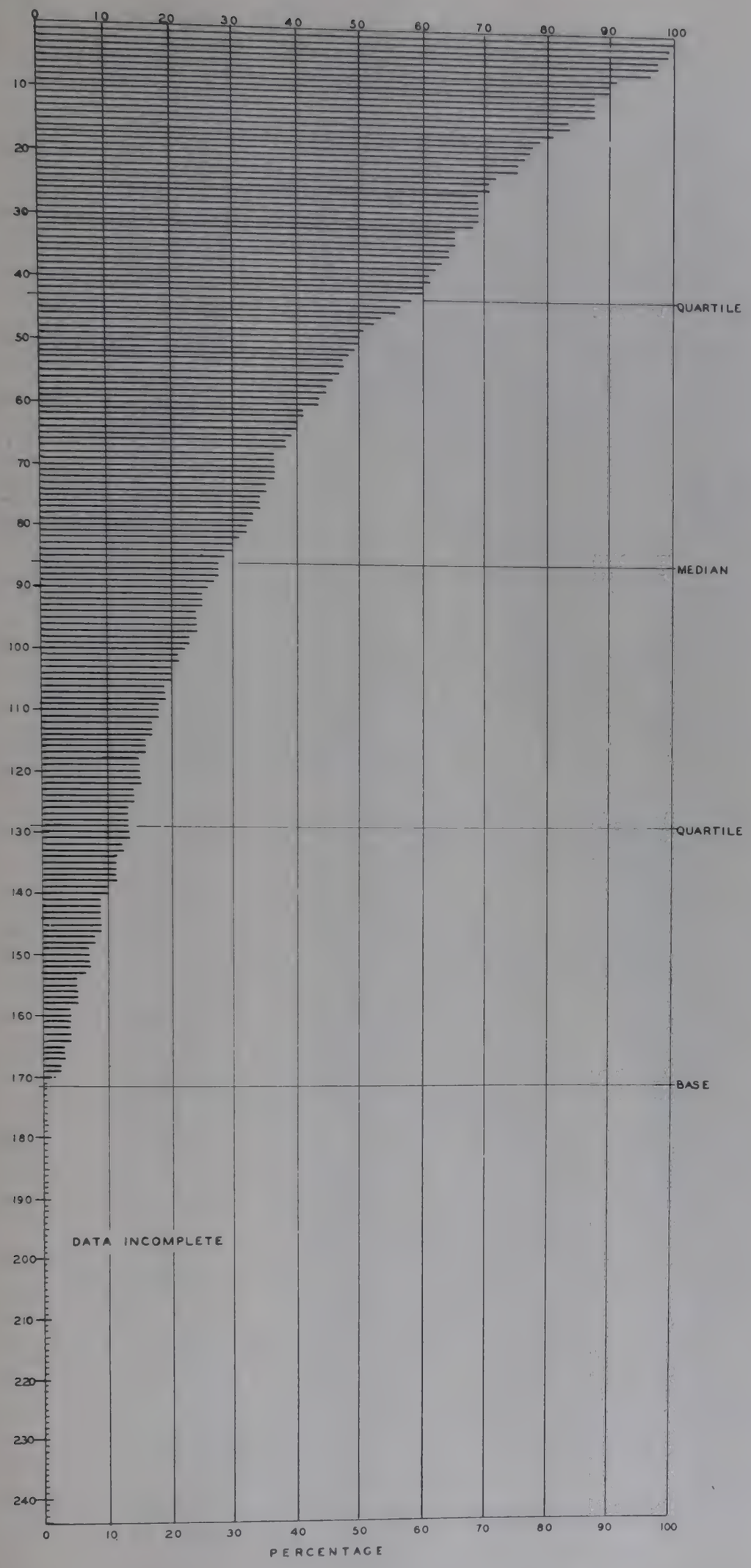
The reduction in this ailment has been the principal factor in the lessening of infant mortality over the last 20 years. The lines in this chart show the number of babies dying from this cause in their first year of life per 1,000 live births. They cover either the two year period 1943 and 1944, or 1942 and 1943. While the median figure is low, 1.6 deaths per 1,000 live births, the range is wide. Better feeding and care hold out the possibility of saving many babies in the communities in the lower part of the chart.

PREMATURE BIRTHS

PERCENTAGE FOR WHOM INCUBATORS WERE USED

The definition of a premature baby is not consistent over the country. Whatever the health department has reported as premature has been accepted. This chart shows what special care is given to those babies whom the departments consider as premature. Data are furnished by only about half the communities. Of this half incubators have been used for all prematures in about one fourth of the group. Every community should make available incubators to help reduce the neonatal death rate.





CHILDREN UNDER ONE YEAR

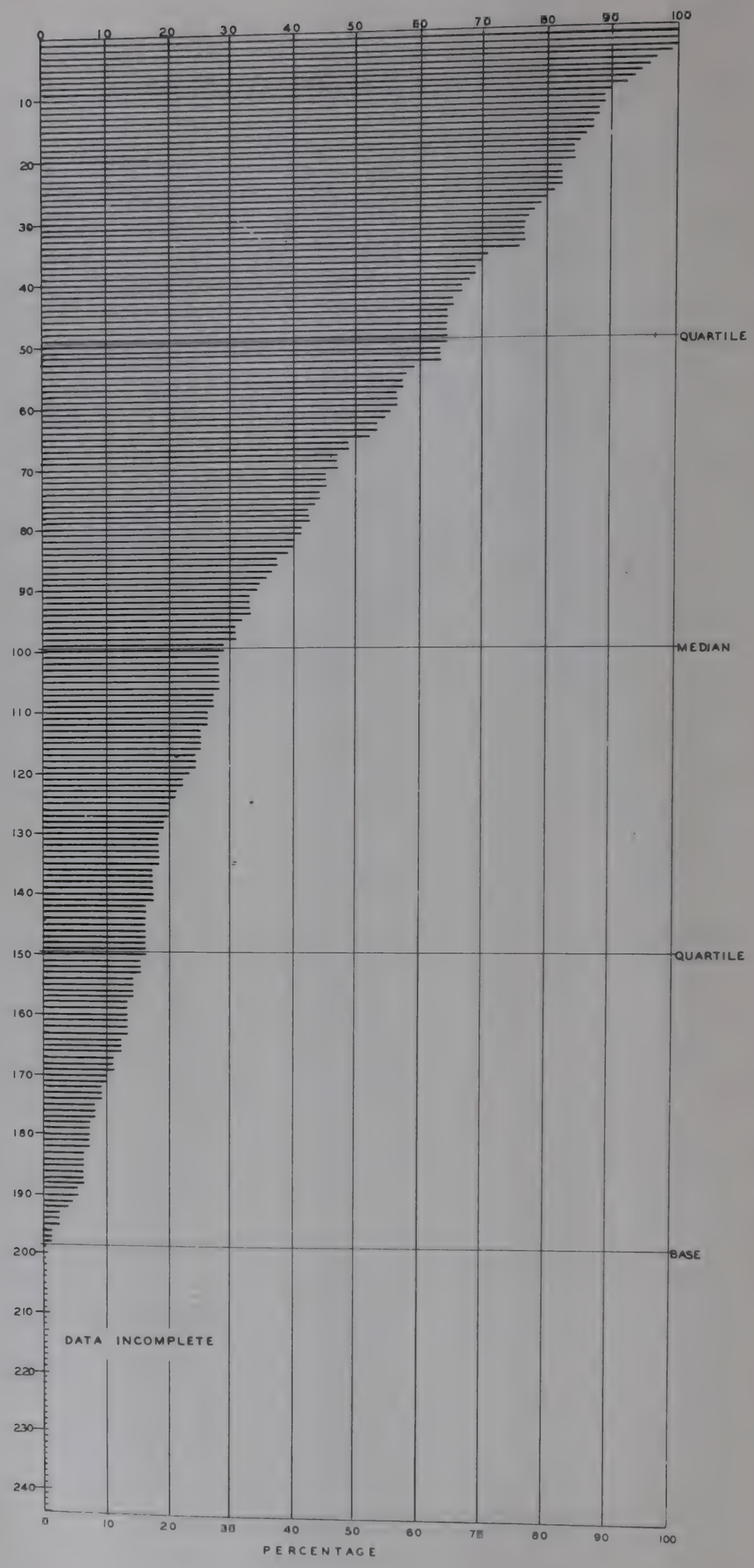
PERCENTAGE UNDER MEDICAL SUPERVISION

The chart shows the percentage of infants known by the health department to have had medical supervision during their first year of life. It is not a complete picture since many babies under supervision of private physicians have not been included in numerous instances. It is not so difficult to get comprehensive information. Sample surveys will give a fairly complete picture. Seventy-two health departments were unable to give any usable data on this subject.

CHILDREN UNDER ONE YEAR

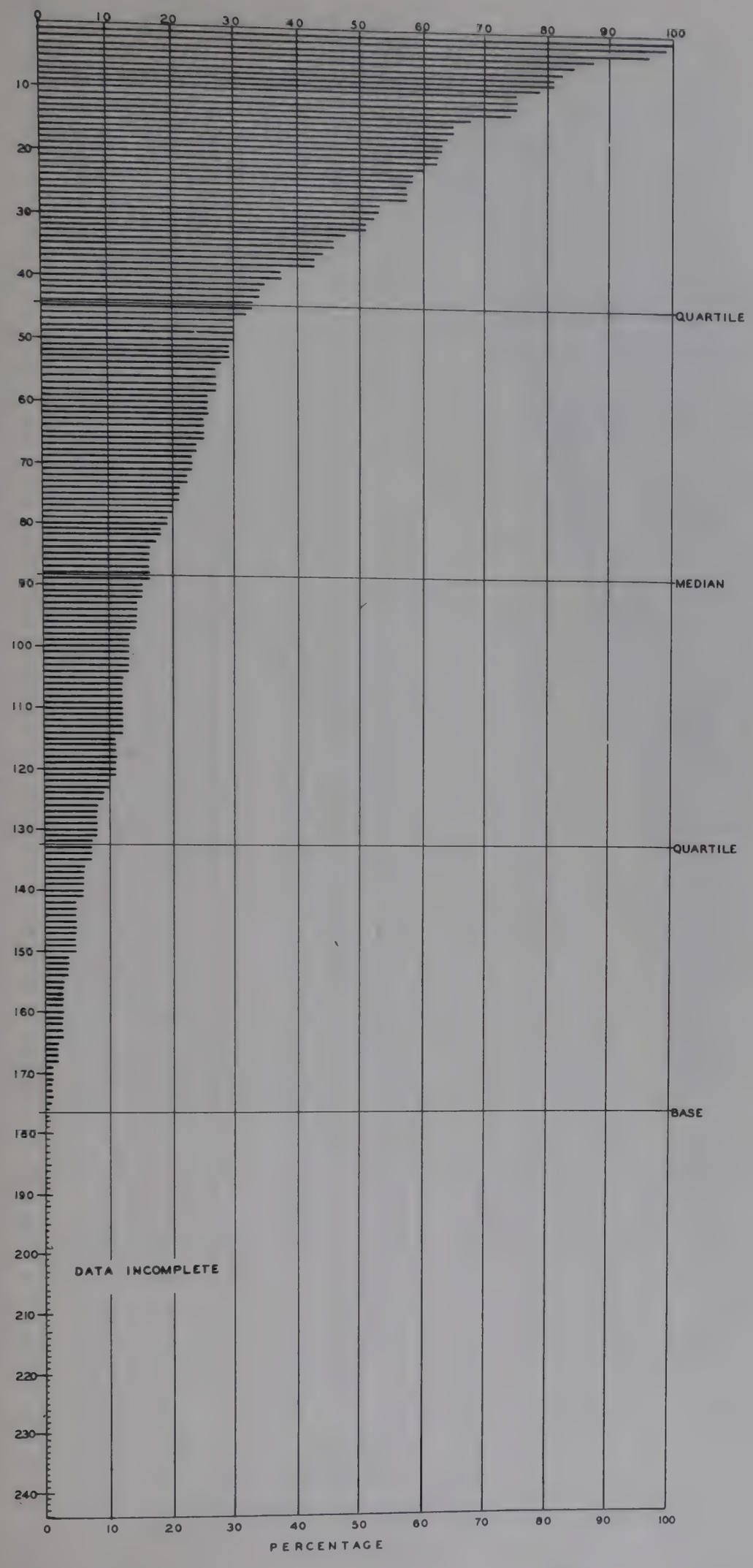
PERCENTAGE UNDER NURSING SUPERVISION

More data are available on nursing supervision than on medical supervision. The work of all voluntary visiting nurse agencies, as well as the health department, is considered here. The three areas at the top of the chart, which reported all babies visited, have active visiting nurse associations. A wide range is shown with a median figure indicating that 29 per cent of all babies were visited during their first year. This median is appreciably less than 39 per cent median shown in last year's "Indices" which is probably to be expected with so many public health nurses going into war service.



CHILDREN UNDER ONE YEAR

PERCENTAGE VISITED BY NURSE WITHIN ONE MONTH

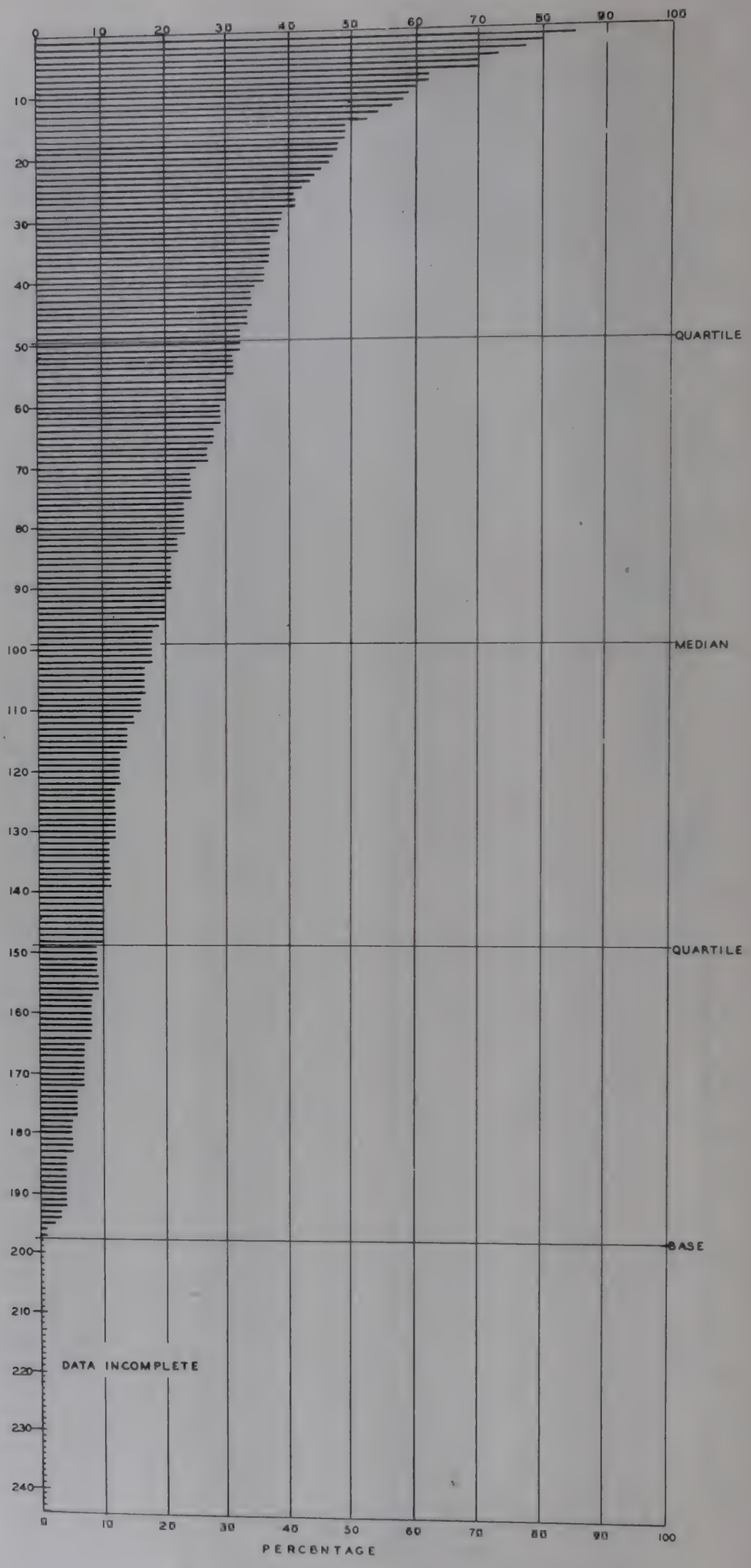


The most effective nursing visits are probably those made during the early days of the baby's life, since about 60 per cent of infant deaths occur during the first month. Not many babies receive this beneficial aid. In fact the median figure is only 16 per cent. In the chart for the preceding year the median was 22 per cent. These data include all nurse visitation both by public and voluntary agencies.

CHILDREN UNDER TWO YEARS

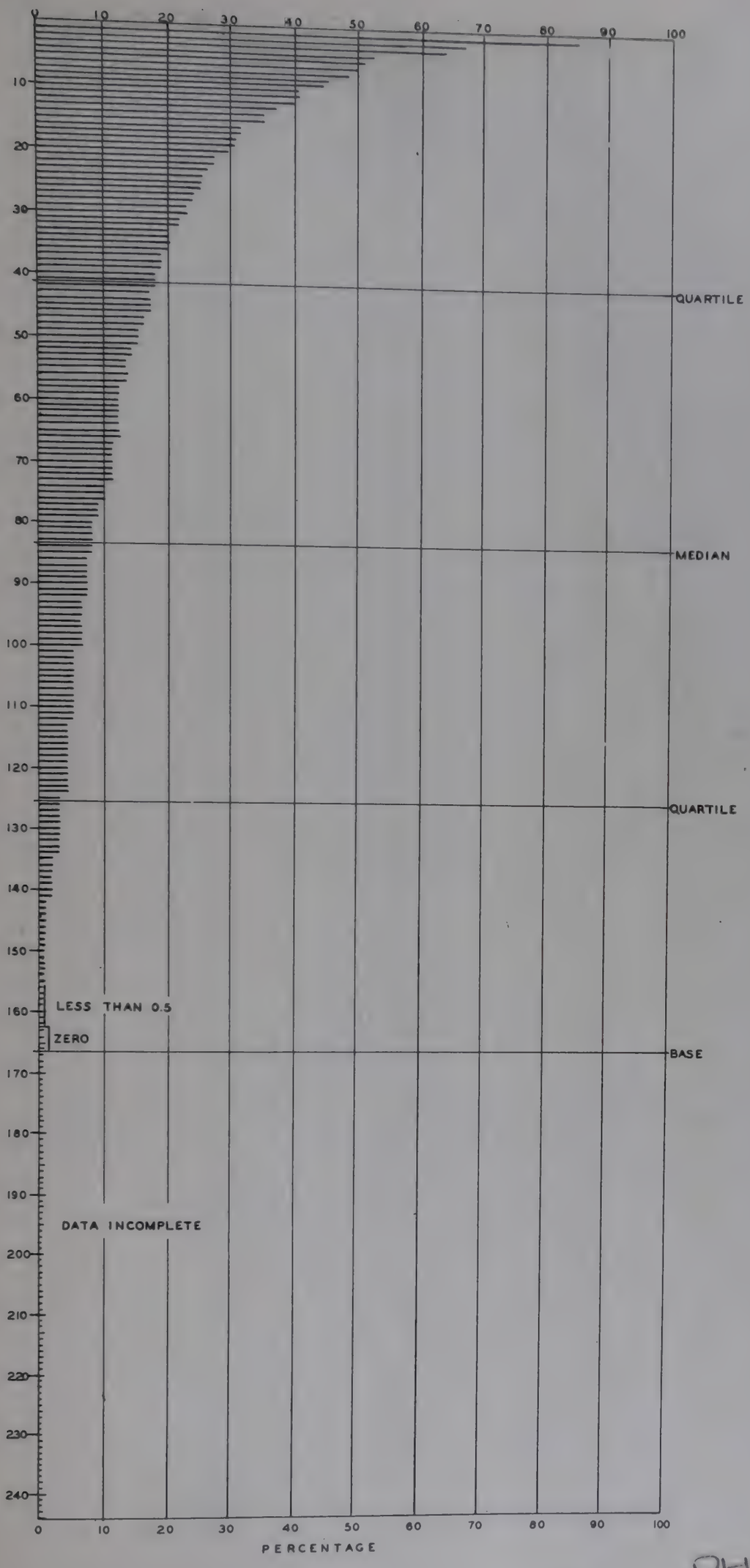
PERCENTAGE GIVEN IMMUNIZING AGENT AGAINST DIPHTHERIA

Certainly by the time the child has reached two years of age, he should have received protective treatment against diphtheria. This chart shows a median figure of only 18 per cent of babies so treated. To be sure this is an understatement rather than otherwise because frequently the number of children immunized by private physicians is not given in addition to the work done by the health department. Even so, this figure is not a good showing against a rich background of experience with this procedure and particularly in view of the continued high prevalence of diphtheria in many communities.



CHILDREN UNDER TWO YEARS

PERCENTAGE VACCINATED AGAINST SMALLPOX

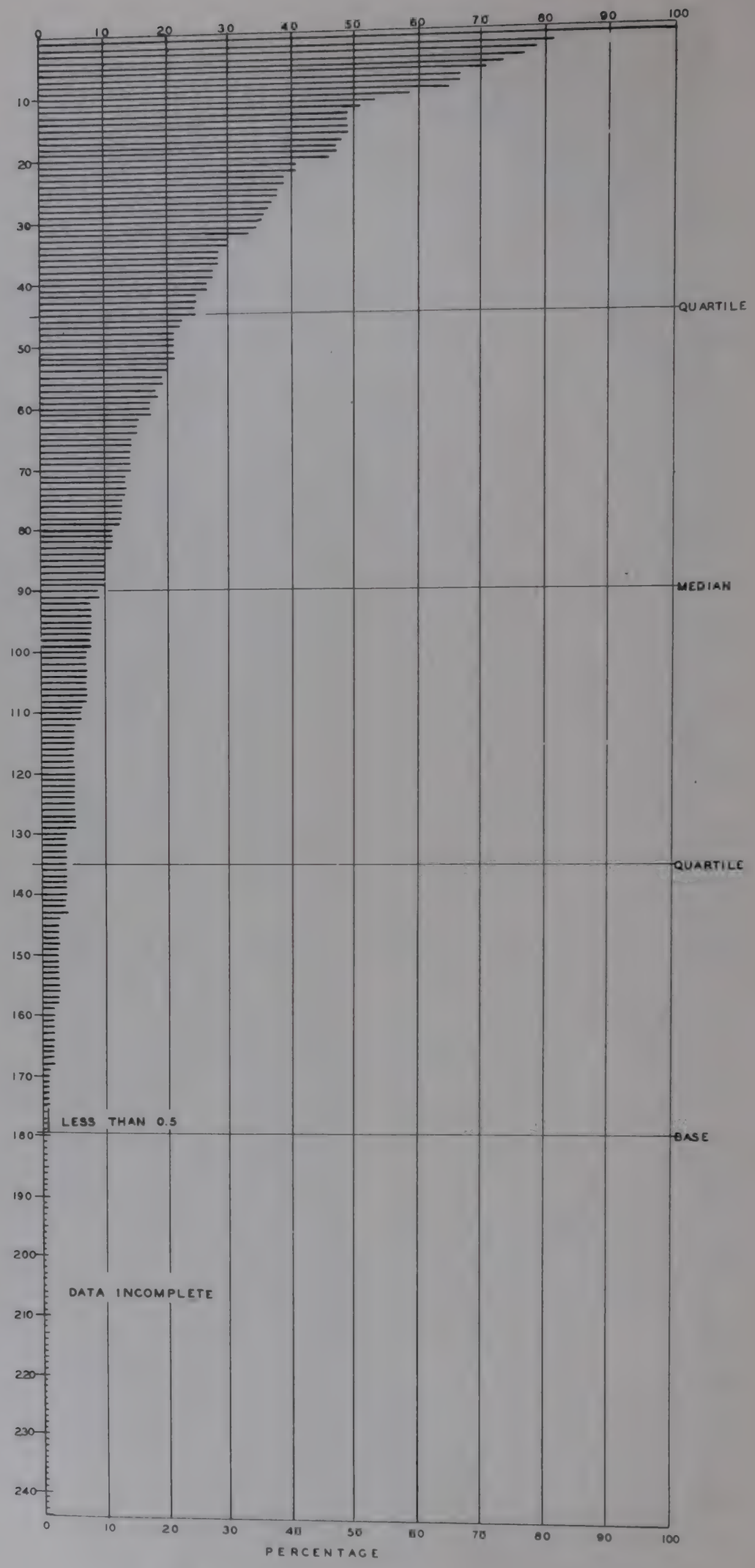


The general freedom from smallpox has had its effect in lessening the thoroughness of vaccination of young children. Many communities can give no data on the extent of this protection. Even among those that do report, the median figure is only 8 per cent, or less than half the proportion given the diphtheria immunizing agent. Here again the vaccination picture is not complete owing to the lack of complete data on the work done by private physicians. Smallpox is always a potential menace. Extensive vaccination of the young should not go unheeded.

CHILDREN UNDER FIVE YEARS

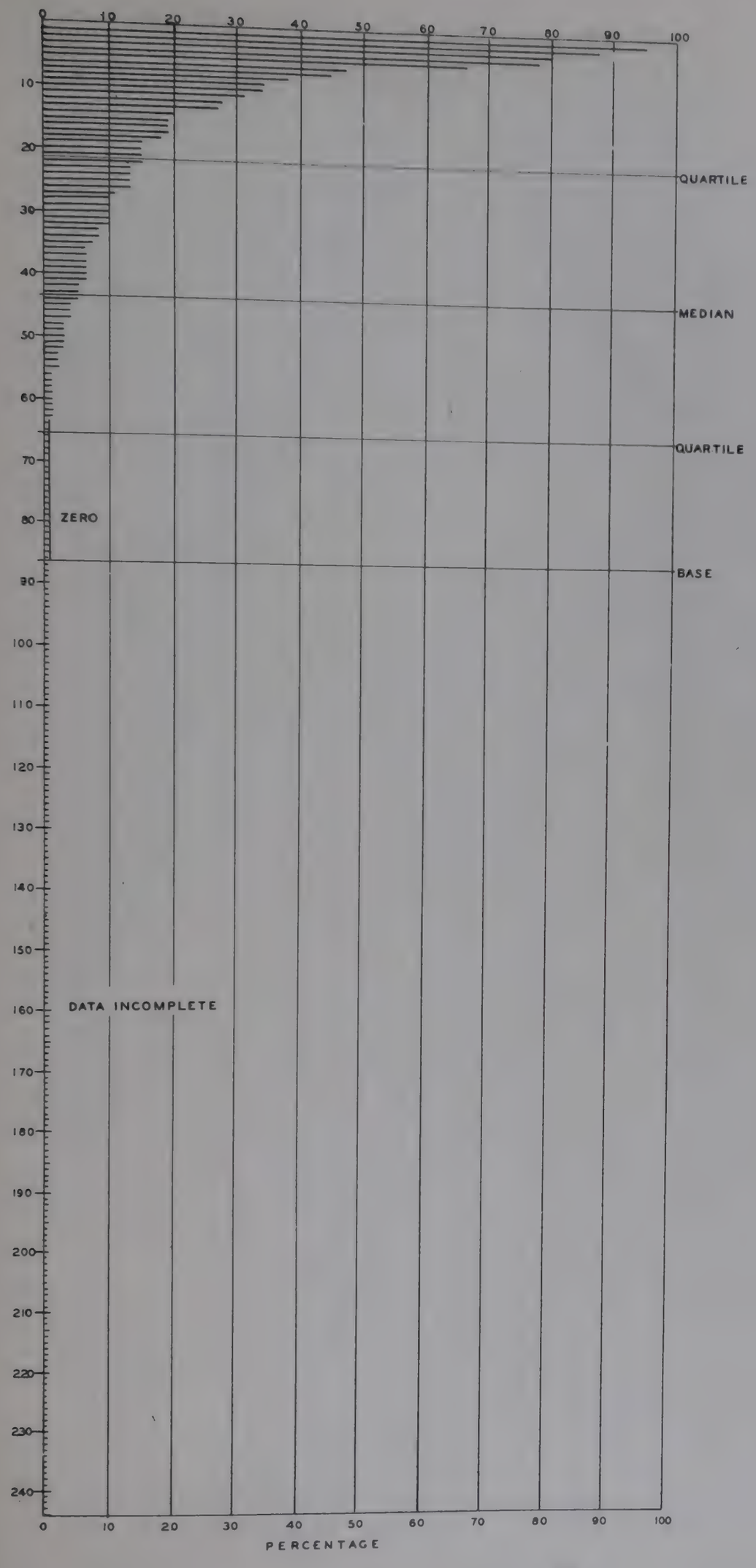
PERCENTAGE UNDER MEDICAL SUPERVISION

This chart reflects the proportion of preschool children under continuing medical supervision so far as the facts are known by health departments. It is probable that the numbers would be greater if records, particularly of those under private medical supervision, were more complete. The community at the top of the chart has such an active visiting nurse association and such complete records of visits to private physicians that their 100 per cent is accepted. A number of communities have not attempted to ascertain by estimate or otherwise how common it is for families to seek medical supervision of preschool children.



CHILDREN TWO THROUGH FIVE YEARS

PERCENTAGE UNDER DENTAL SUPERVISION

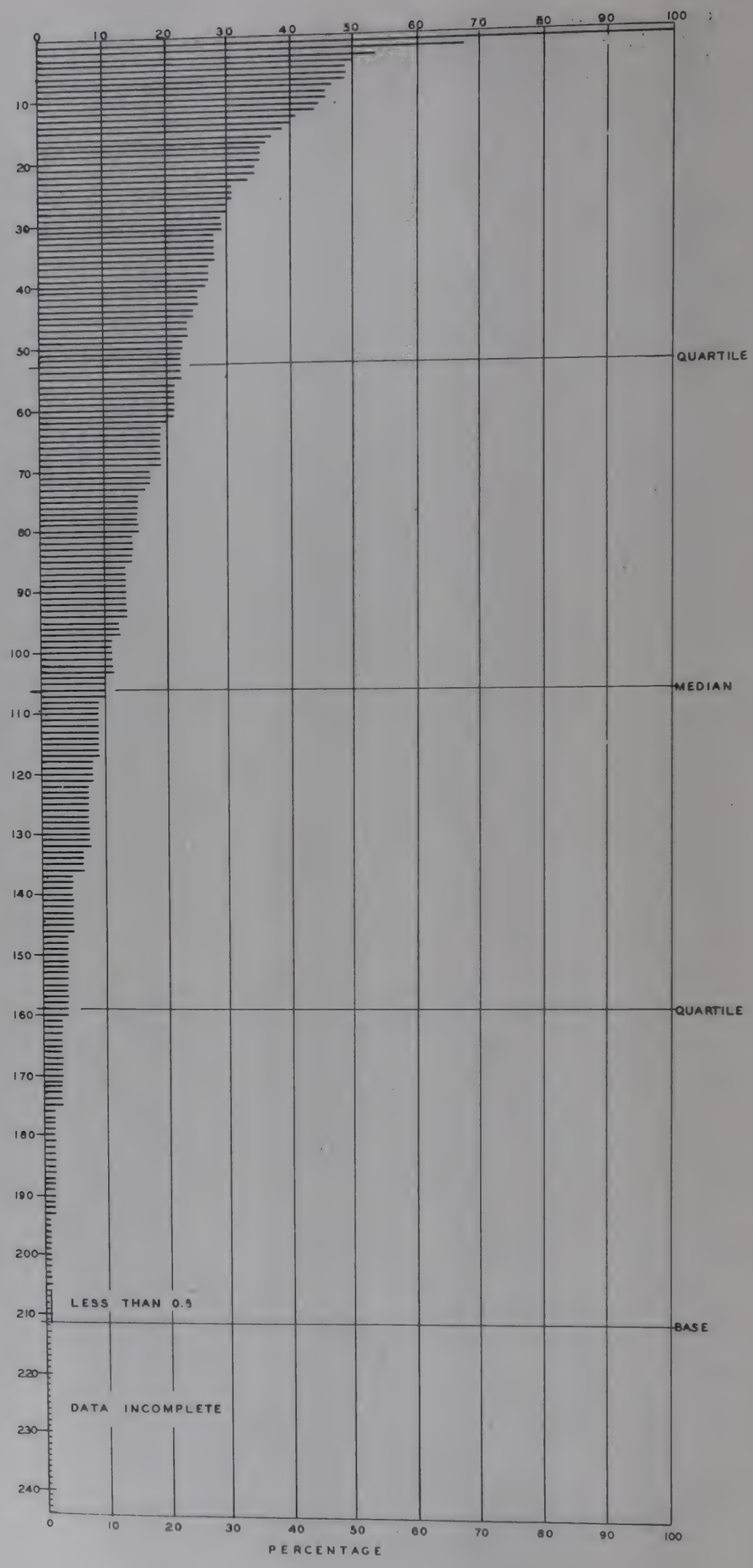


Less is known about the extent of dental supervision among children below school age than for any topic covered by these charts. Only 86 communities volunteered answers. Admittedly this is a difficult item to obtain but ideally the health department should know whether or not children are receiving dental attention.

CHILDREN UNDER FIVE YEARS

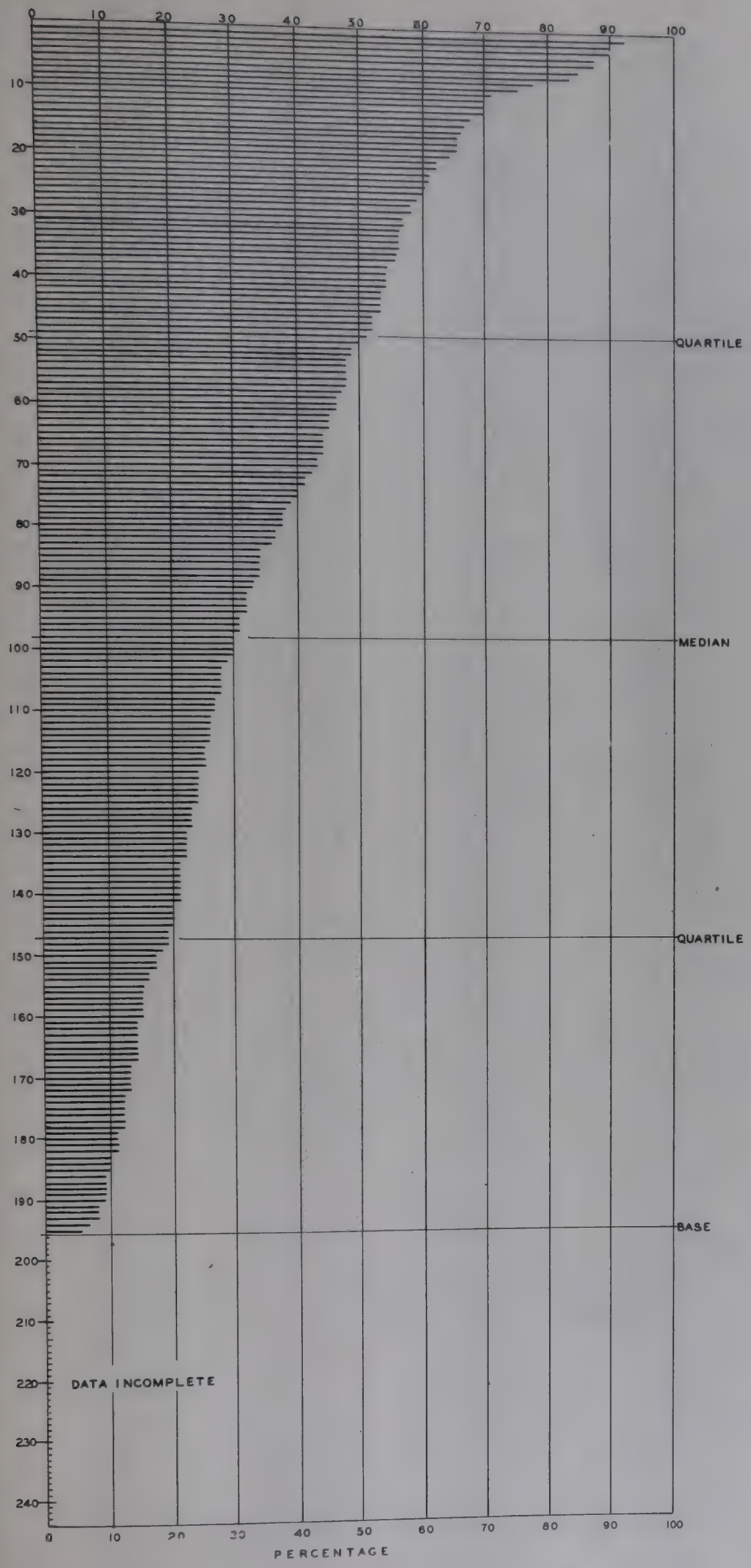
PERCENTAGE UNDER NURSING SUPERVISION

There is an interesting contrast between this chart and that for dental supervision. Nursing agencies, public and private, are equipped to keep records of their work. More communities therefore report on this question. The numbers of preschool children under nursing supervision are not large however, the median figure being only 10 per cent. In the upper quarter of the chart are a number of areas that reach a substantial proportion of preschool children through these nursing services.



CHILDREN UNDER FIVE YEARS

PERCENTAGE GIVEN IMMUNIZING AGENT AGAINST DIPHTHERIA



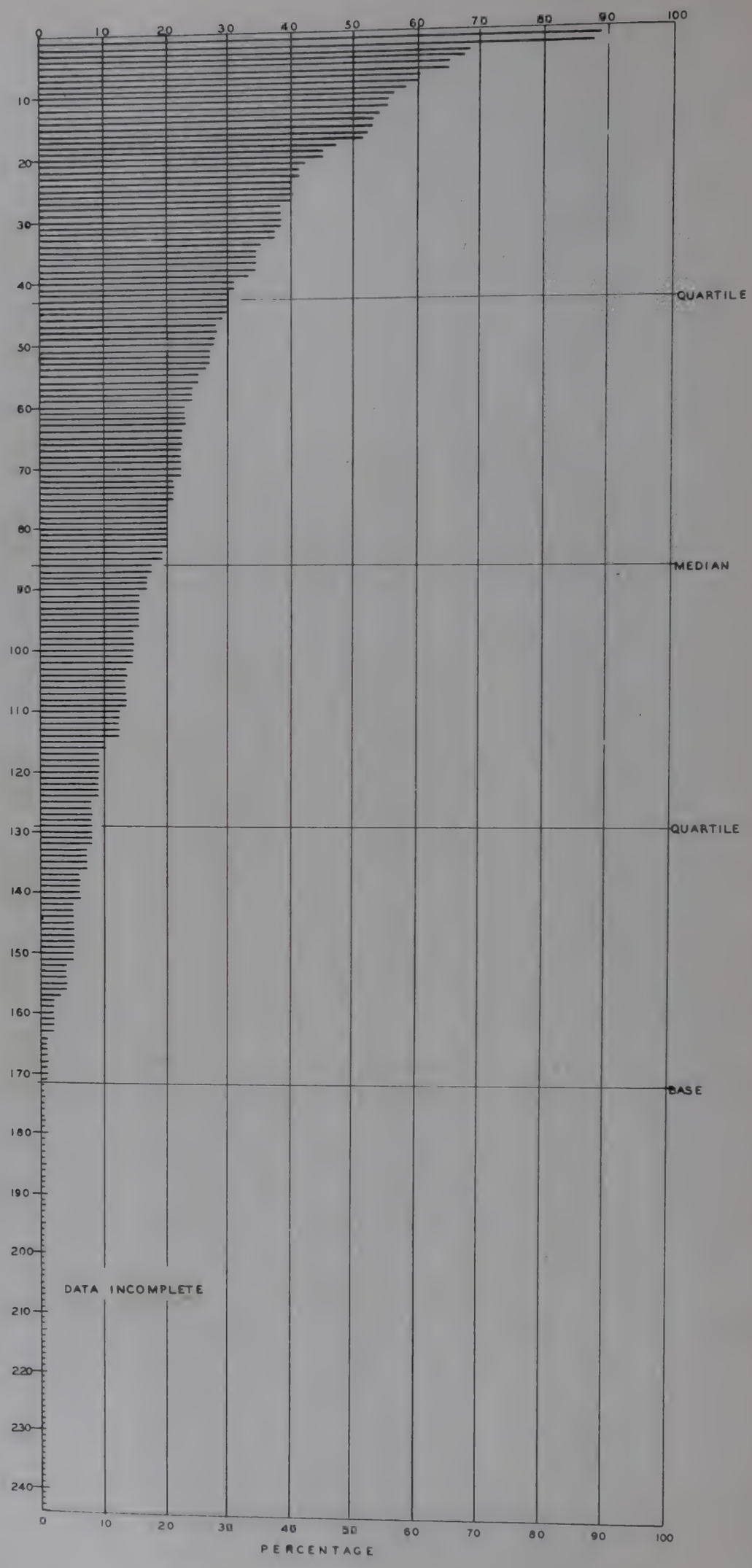
For some time it has been accepted that immunization of 60 per cent of preschool children (under five years of age) will provide insurance against any general outbreak of diphtheria. Twenty-five communities have reached this level. The median figure is 30 per cent given the protective treatment. Lack of information from private physicians is not an insurmountable barrier to a community-wide understanding of the extent of protective treatment of young children, for many departments do manage to secure this information.

The larger areas show to slightly better advantage with a median of 40. The corresponding median is 30. in the smaller communities.

CHILDREN UNDER FIVE YEARS

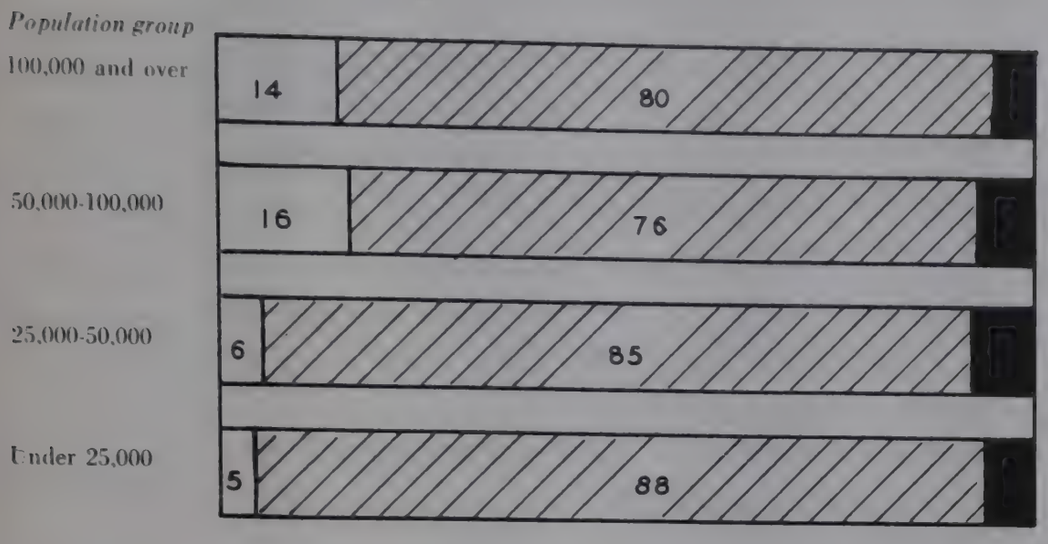
PERCENTAGE VACCINATED AGAINST SMALLPOX

Vaccination of young children is less extensive than diphtheria protection. The median of the former is 18 per cent and of the latter 30 per cent. Judging by the larger number of communities that report no data on this subject, the interest in vaccination is not as great as in immunization. The practice of delaying vaccination until children enter school is quite common.

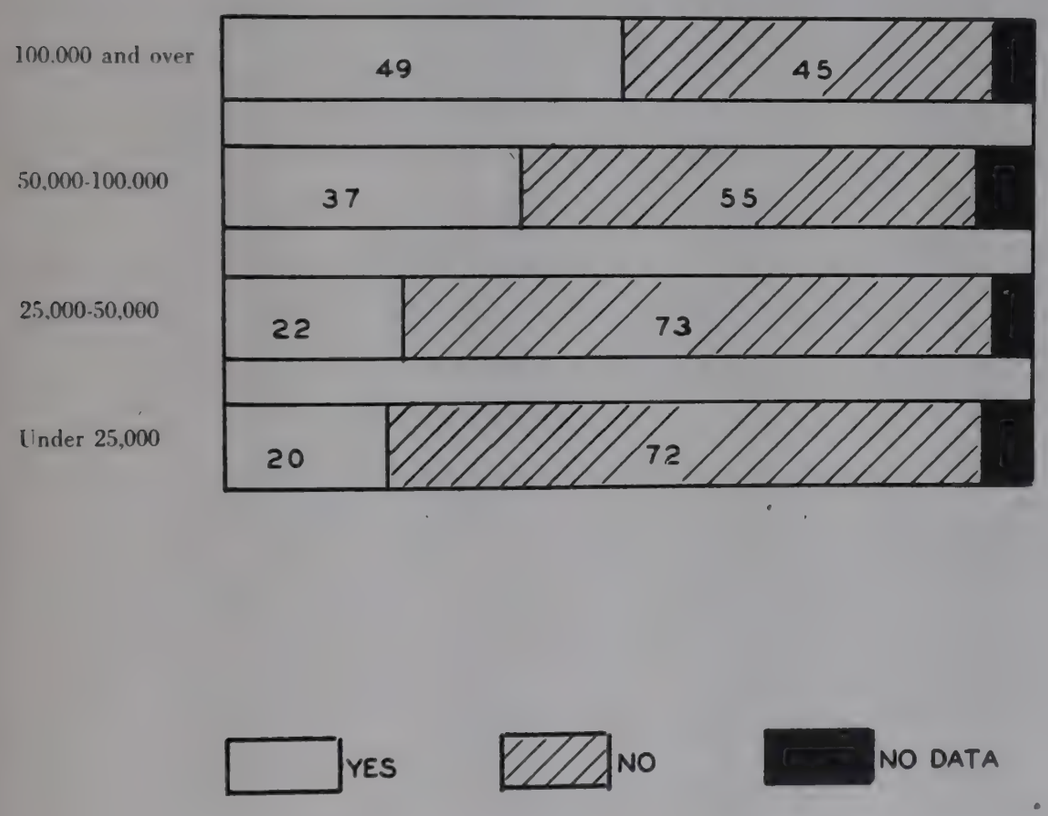


PRESCHOOL HEALTH

IMMUNIZATION AGAINST DIPHTHERIA REQUIRED FOR ENTRANCE TO SCHOOL: PERCENTAGE OF COMMUNITIES REPORTING



VACCINATION AGAINST SMALLPOX REQUIRED FOR ENTRANCE TO SCHOOL: PERCENTAGE OF COMMUNITIES REPORTING



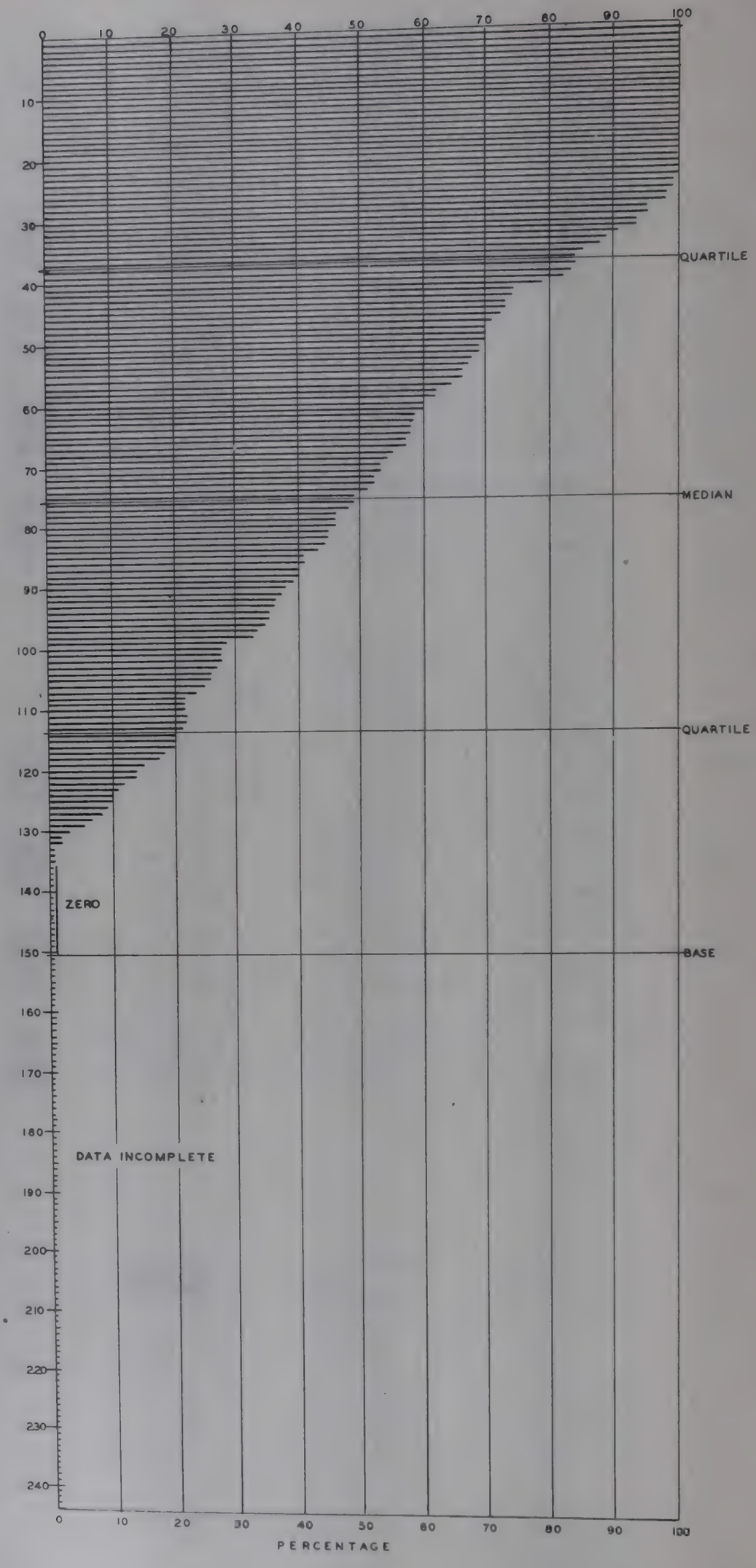
The smallpox vaccination requirement for school entrance is much more common than the requirement of diphtheria immunization. Both of these requirements are more frequent the larger the community.

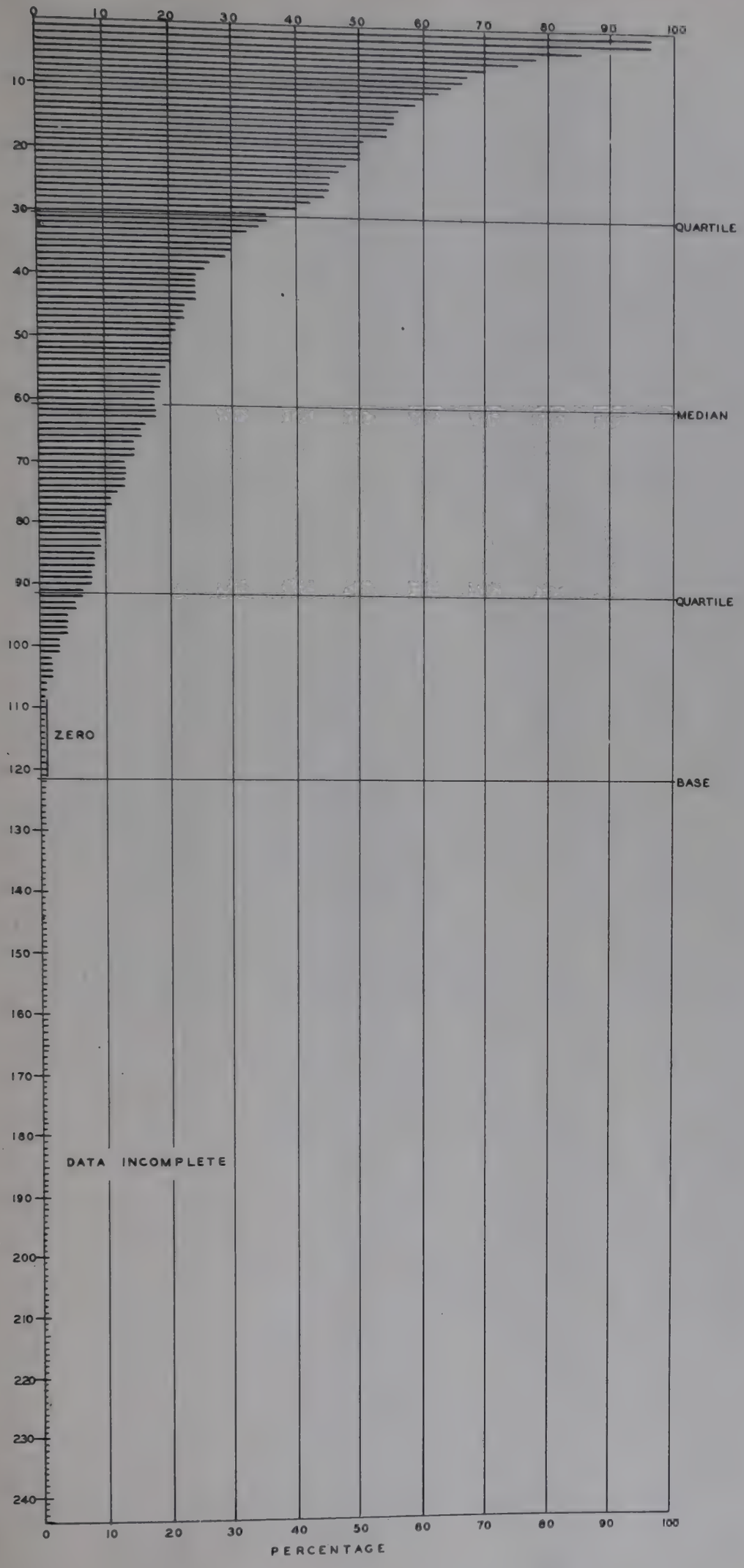
Awareness of the legal requirement may influence some families to postpone vaccination till school entrance. Certain it is that the number of babies and preschool children vaccinated is much less than the number immunized against diphtheria.

ENTERING SCHOOL CHILDREN EXAMINED

PERCENTAGE WITH PARENT PRESENT

The Evaluation Schedule specifies that children examined during the year prior to entering school may be included along with those examined at the time of school entrance. These examinations are meant to include those done in private physicians' offices, or in the headquarters of public or voluntary agencies, or in the school itself, by physicians of the health department or board of education. Careful, unhurried examinations in the presence of a parent are believed to provide a unique opportunity for direct education by the physician. The value of the examination without the presence of a parent is regarded as of extremely limited value and furthermore much nursing time in repeated home follow-up visits is wasted. Twenty-four communities fully recognize these values for, of the entering children who were examined, the parents were present in each instance.





ELEMENTARY SCHOOL CHILDREN

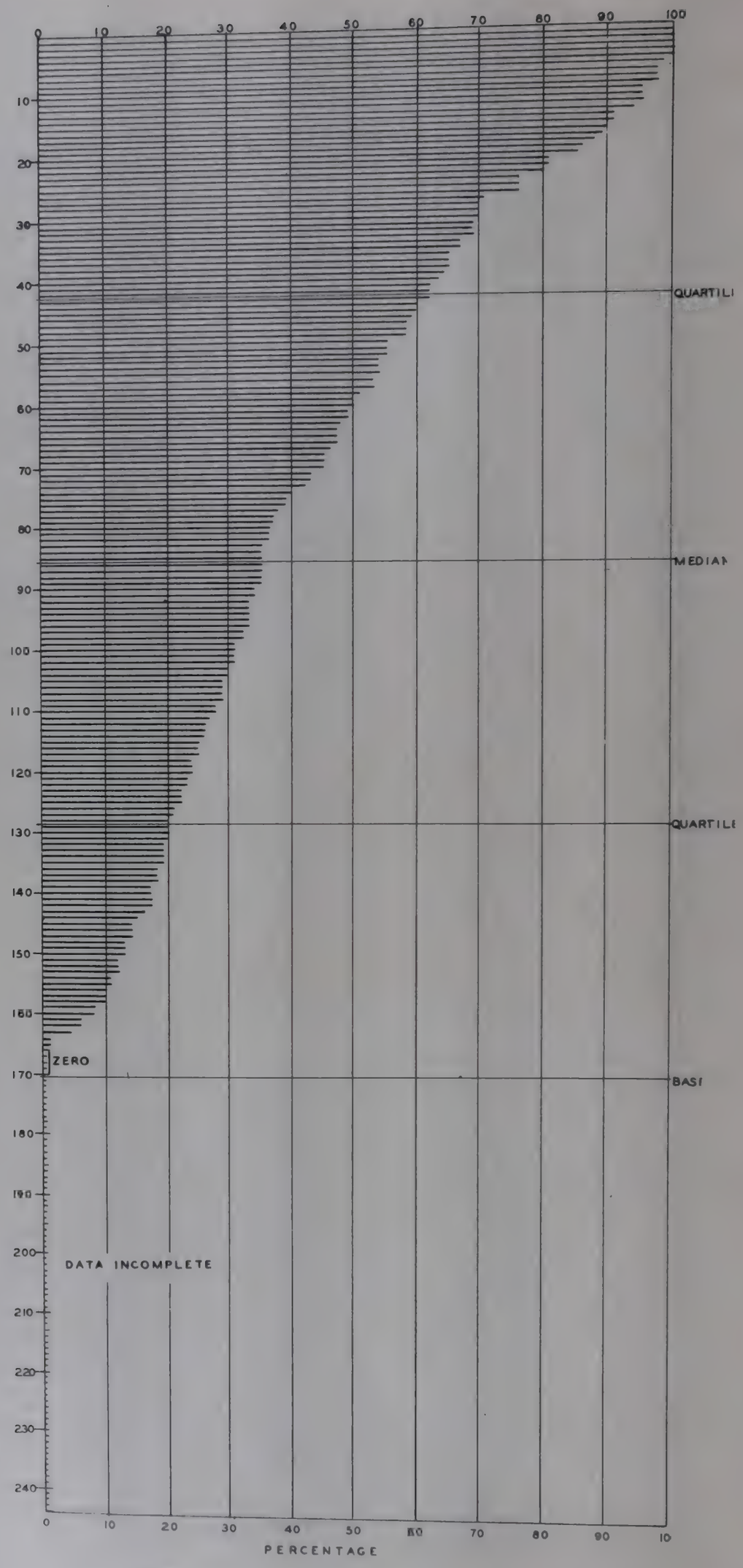
PERCENTAGE RECEIVING CORRECTIVE DENTAL WORK

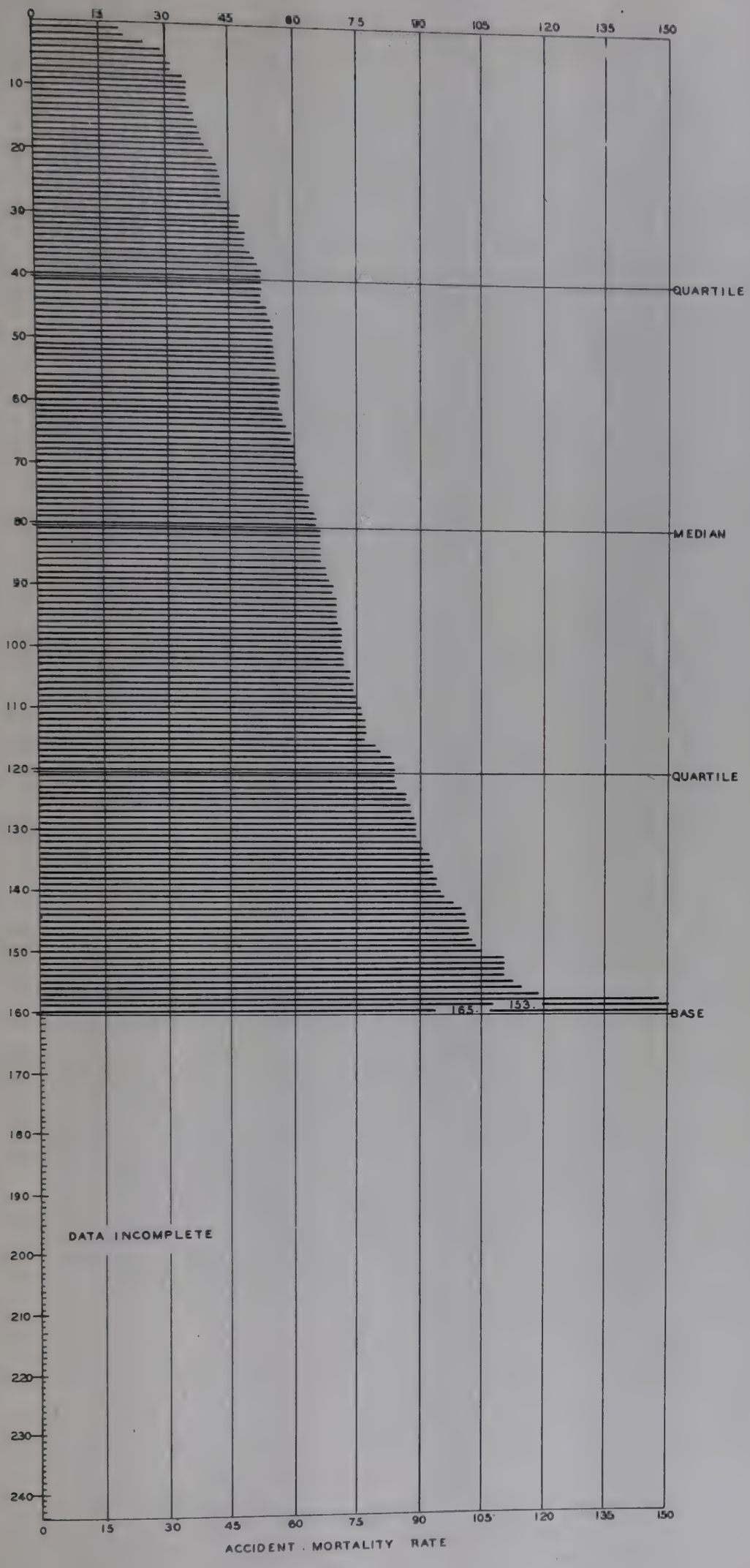
These figures are not easy to obtain with completeness. What is here shown is really the percentage known by the health department. Relatively few communities know these facts. Even recognizing these inadequacies it is believed that corrective dental work for school children falls far short of what is needed. The larger areas have the advantage with a median of 24. In the smaller communities the median is only 15.

SCHOOL CHILDREN

PERCENTAGE ATTENDING SCHOOLS WITH HOT LUNCH FACILITIES

These lines show the percentage of school children attending schools in which hot lunches are available. The median figure is 35 per cent. The range of practice is wide, however. The medians for large and small communities are 53. and 33.





TOTAL ACCIDENTAL DEATHS PER 100,000 POPULATION

FIVE YEAR PERIOD

The median for the last five years is 64.7, or appreciably less than the figure for the United States in 1943 (73.9). The wide differences shown in the chart indicate a continued need for safety education. The people of the communities in the lower ranges of the chart may be said to live "dangerously" in contrast to those in the top quarter.

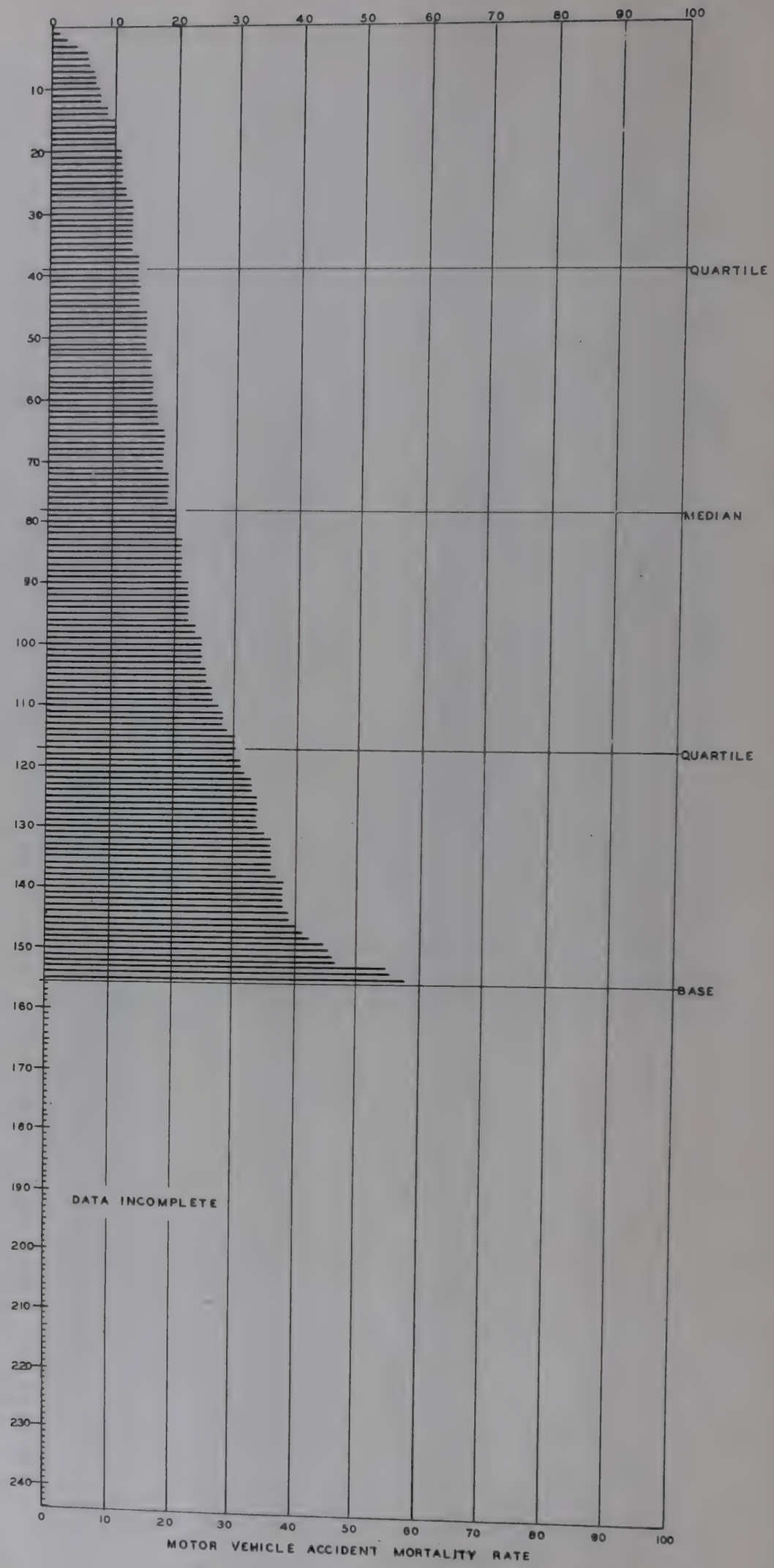
ACCIDENTAL DEATHS

MOTOR VEHICLE DEATHS PER 100,000 POPULATION

FIVE YEAR PERIOD

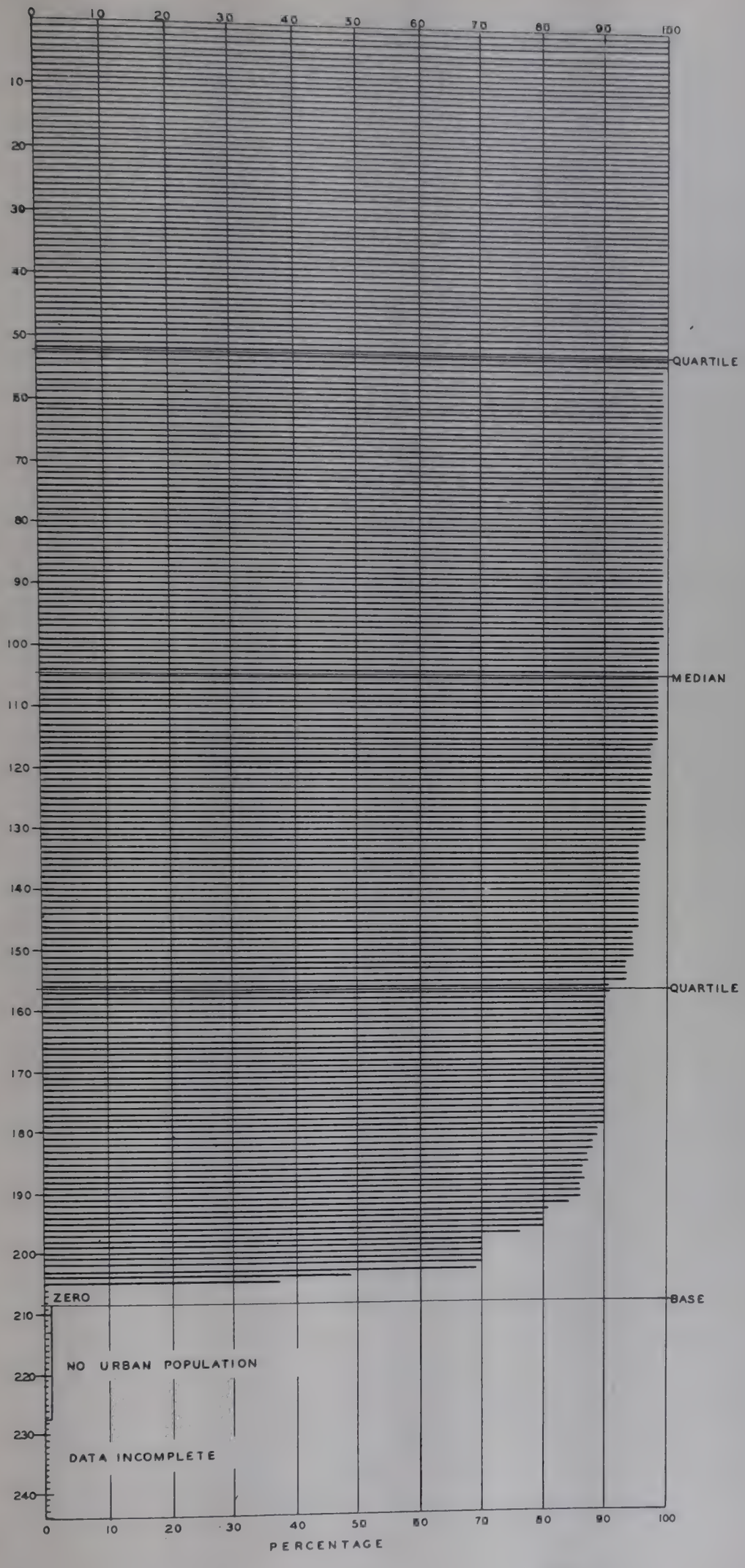
The median death rate from motor vehicle accidents over the last five year period is 19.6 per 100,000 population, practically the same as that shown in last year's indices. The rate for the United States in 1943 was 17.8.

Deaths from other forms of accidents were not given with sufficient completeness to permit presentation in chart form.



POPULATION IN COMMUNITIES OF MORE THAN 2,500

PERCENTAGE SERVED WITH APPROVED WATER SUPPLIES

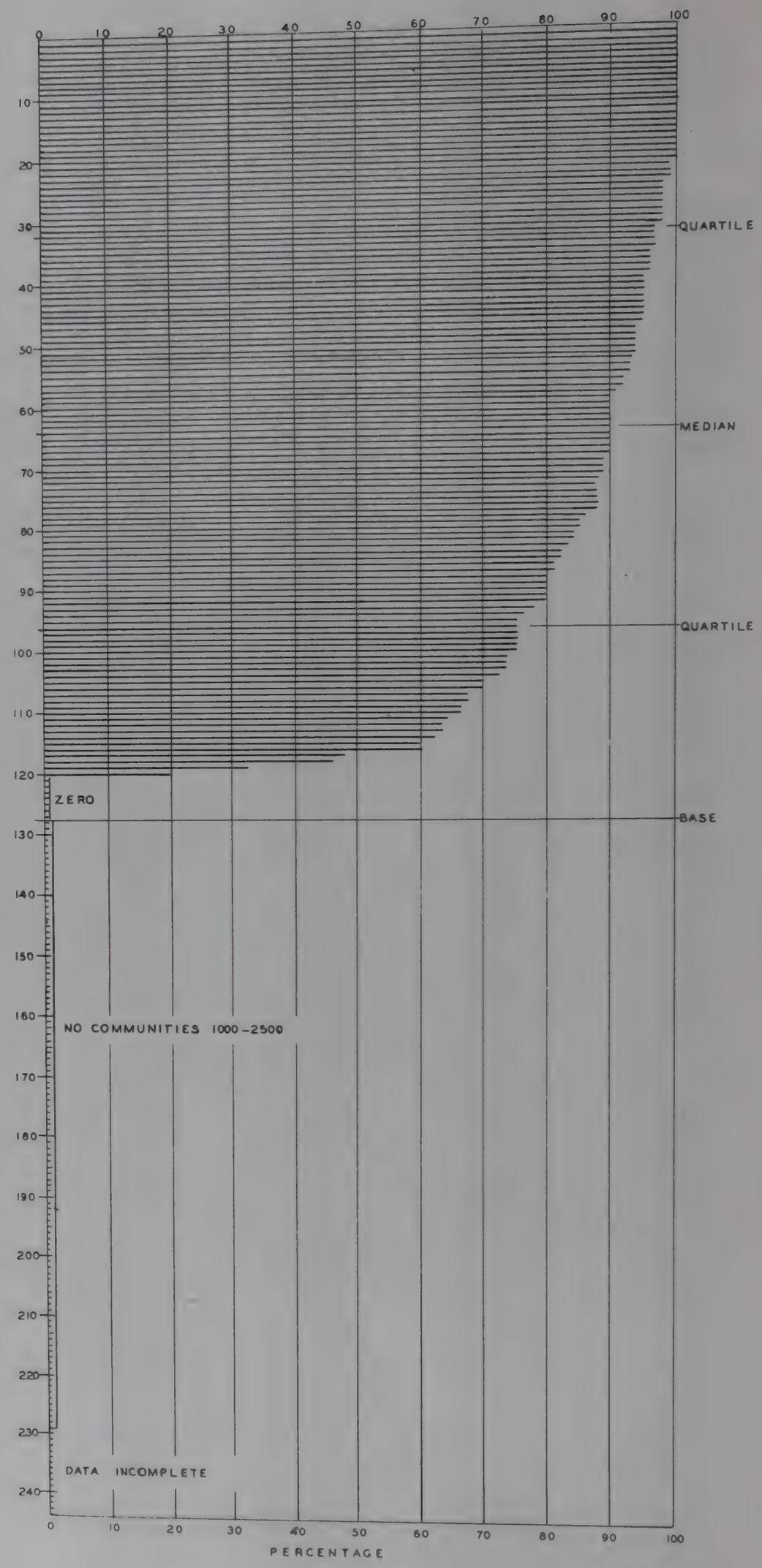


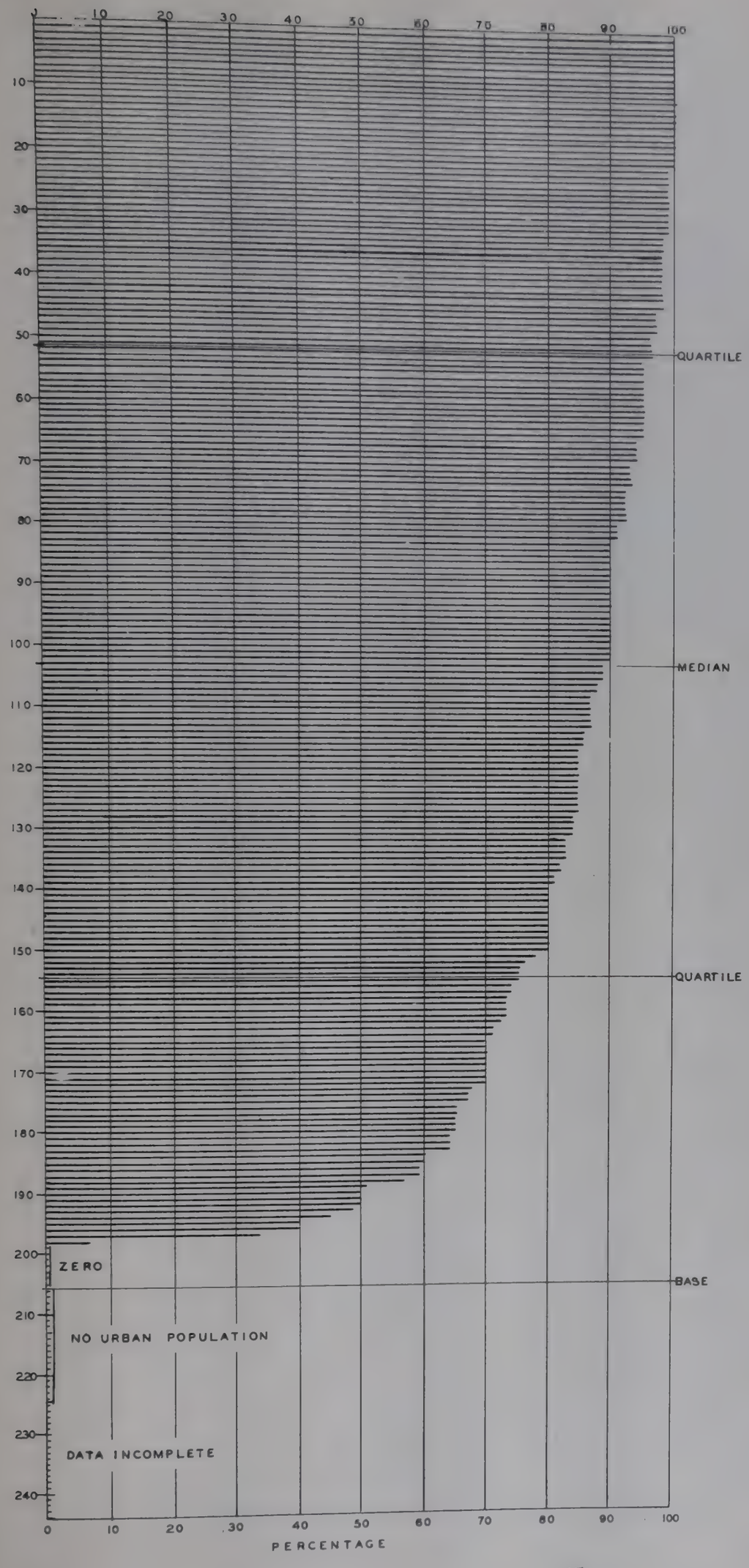
The value of a safe water supply is widely appreciated in this country. This chart shows the most complete record of achievement of any chart in the book. Approved water supplies reaching 98 per cent of the population (in towns and cities of 2,500 population and over) are found in more than half the areas reporting. Extension of the approved supply to reach more people is still needed in a number of communities. Sixteen areas were unable to report on this item.

POPULATION IN COMMUNITIES OF 1,000 - 2,500

PERCENTAGE SERVED WITH APPROVED WATER SUPPLIES

Only about half of the areas reporting have communities in this population group. The median percentage of people served by approved public water supplies is 90 per cent. This is less complete than the services in larger towns and cities, as would be expected. Seven communities of this size have no approved public water supplies.





POPULATION IN COMMUNITIES OF MORE THAN 2,500

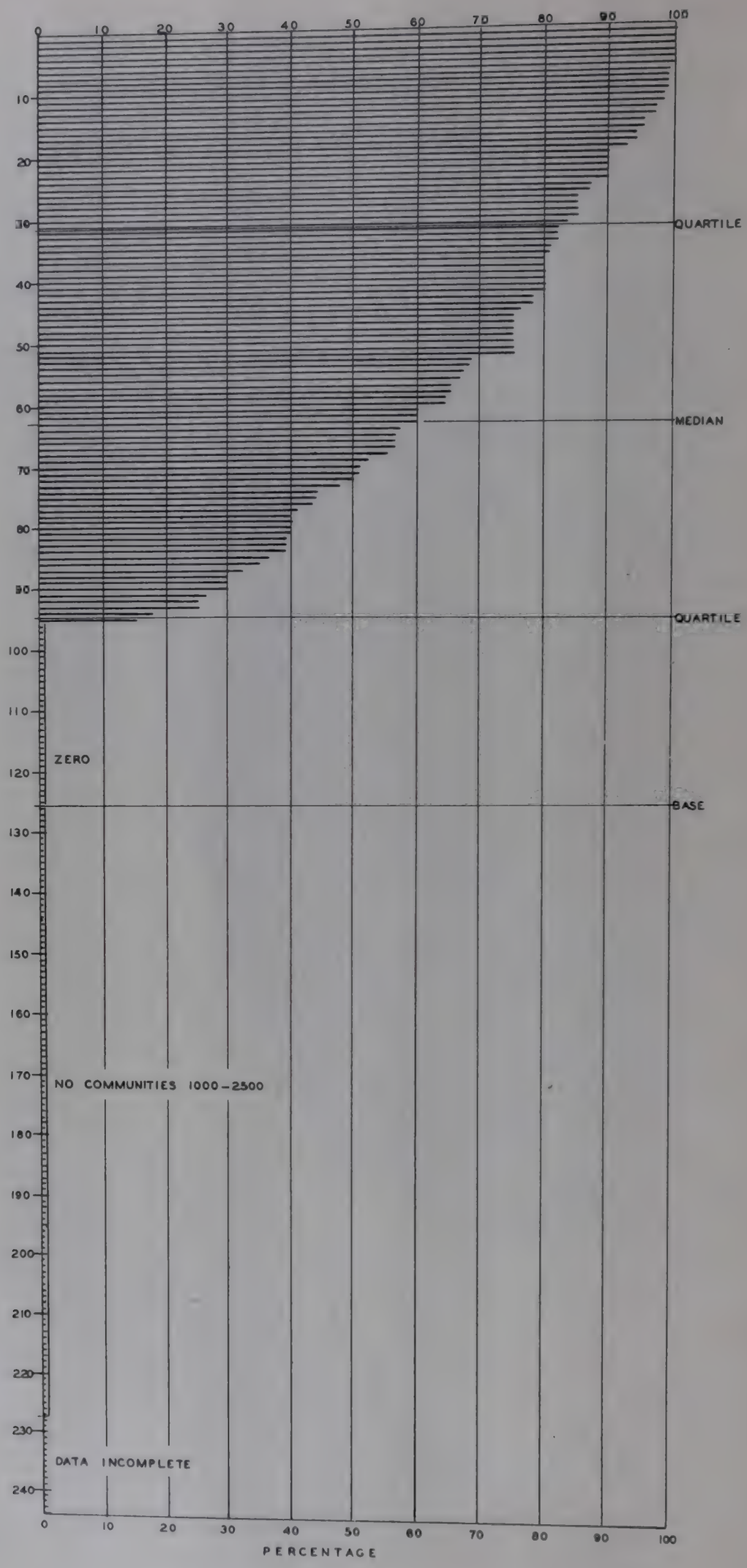
PERCENTAGE SERVED WITH APPROVED SEWERAGE SYSTEMS

This is likewise a good record. The median is 89 per cent. Further extension of these facilities ought to be one of the major items in a postwar construction program. While not under the direct supervision of the health officer, he does have a vital interest in the extent of these facilities and also in the methods of ultimate disposal of sewage. In the more populous districts sewerage systems serve a greater proportion of people. The median is 75. In the smaller areas the median is 55.

POPULATION IN COMMUNITIES OF 1,000 - 2,500

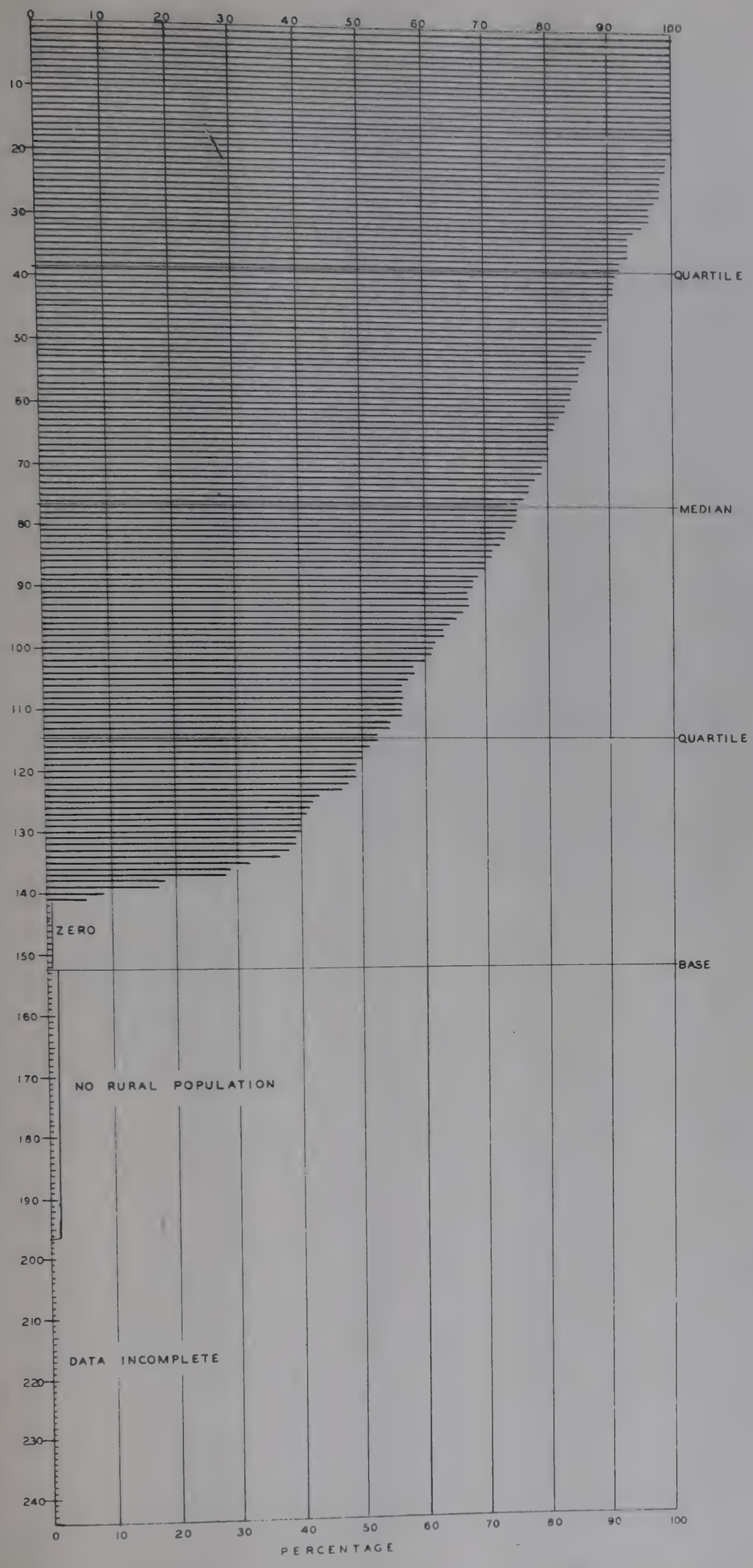
PERCENTAGE SERVED WITH APPROVED SEWERAGE SYSTEMS

There are many health jurisdictions having no towns of this population. The median indicates that 60 per cent of the population in these areas are served by approved sewerage facilities. A quarter of the areas reporting these facts have no public sewerage facilities whatever.



RURAL SCHOOL POPULATION

PERCENTAGE SERVED WITH APPROVED WATER SUPPLIES



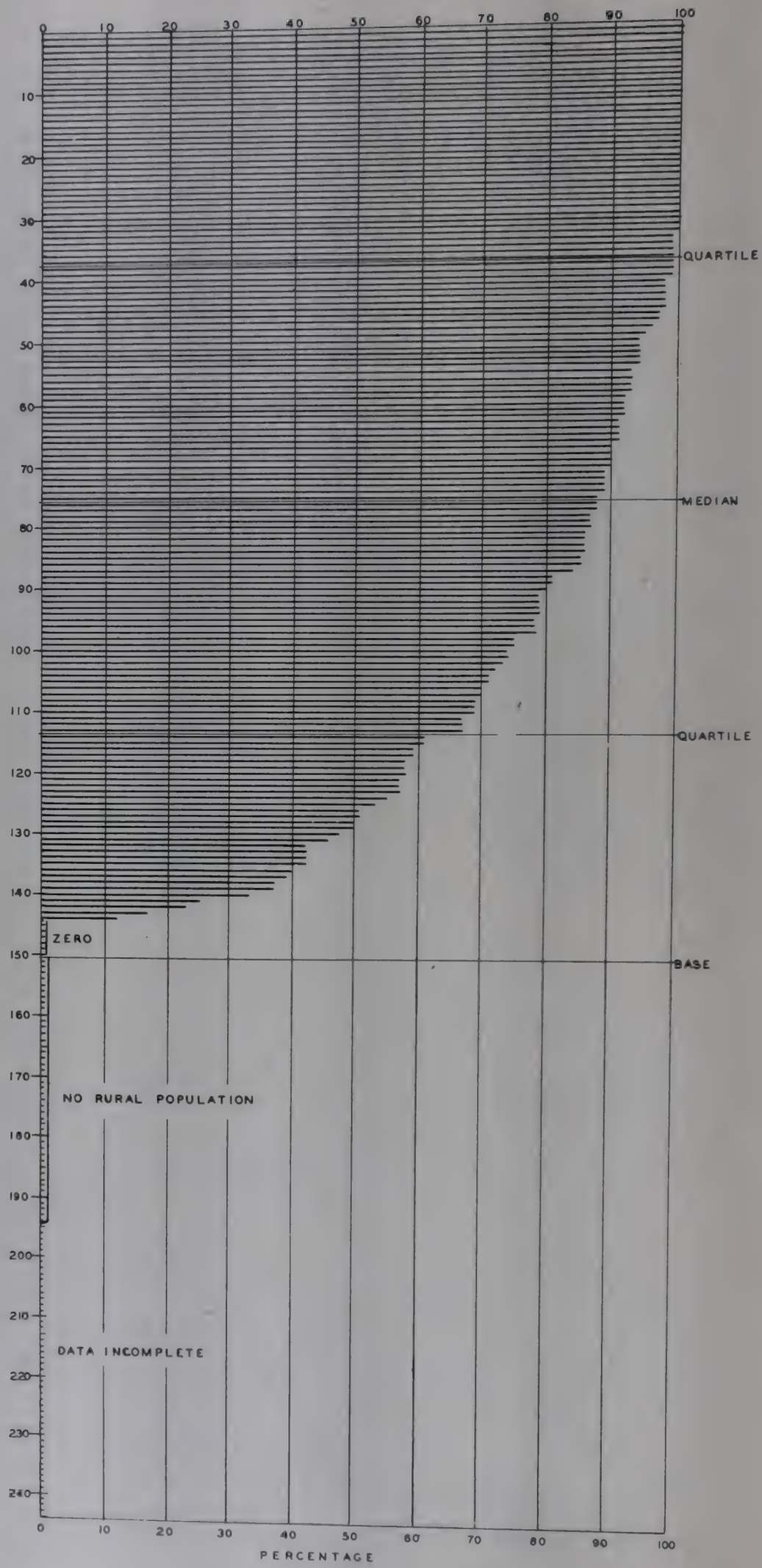
Water supplies of doubtful safety are still being used by a large group of rural school children. The median figure indicates only 75 per cent of the rural school children in these communities served with approved drinking water. This is a matter of great consequence and should not be neglected. The sanitary engineer and sanitarian have an important educational job ahead of them to convince rural school boards of the need for improvement in these matters.

The larger districts have made more progress in this regard, the median being 88. In the smaller areas, it is 72.

RURAL SCHOOL POPULATION

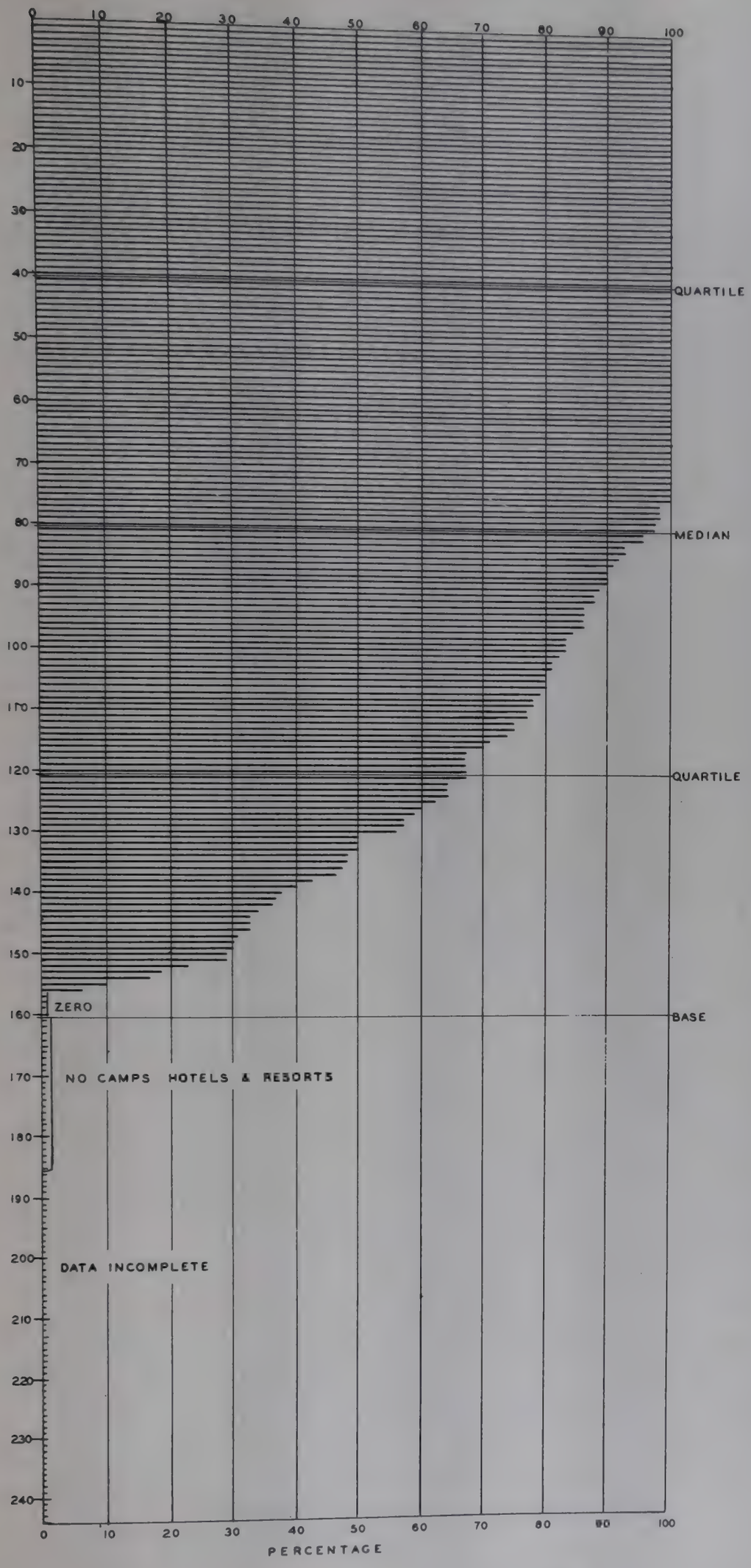
PERCENTAGE SERVED WITH APPROVED MEANS OF EXCRETA DISPOSAL

Thirty-three of the 150 communities reporting believe that all their rural schools are equipped with sanitary privies or other approved methods of excreta disposal. This is a fine record. There are many other areas however, where this safety measure has not been carried out with completeness. A clear-cut task faces the sanitarians of these health departments. This subject deserves inquiry among those communities which do not know these facts.



PUBLIC CAMPS HOTELS AND RESORTS

PERCENTAGE SERVED WITH BOTH APPROVED WATER SUPPLIES AND APPROVED MEANS OF EXCRETA DISPOSAL



Of the 160 communities reporting, 75 state that 100 per cent of their camps, hotels and resorts are equipped with approved water supplies and means of excreta disposal. This subject deserves more consideration on the part of the remaining communities and particularly the large group appearing below the base line at the bottom of the chart in which these essential facts are apparently unknown.

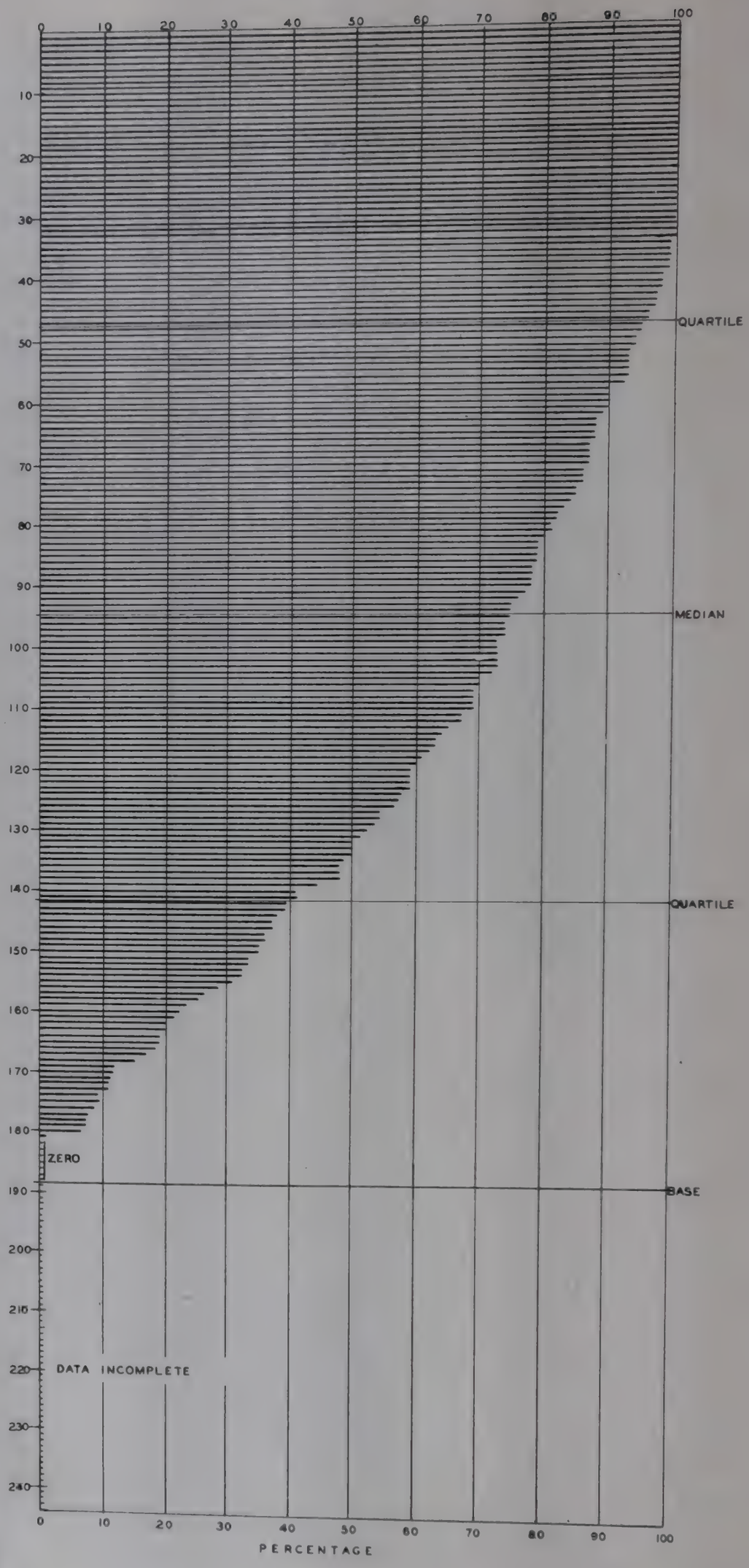
RESTAURANTS LUNCH COUNTERS AND TAVERNS

PERCENTAGE WITH APPROVED SANITATION AND FOOD HANDLING FACILITIES

Thirty-four communities report that all the public places serving food meet all the standards set for sanitation and handling of food. The term "standard" is a variable one. Some communities are much more strict in their standards than others. We have accepted the data as presented by the individual health departments.

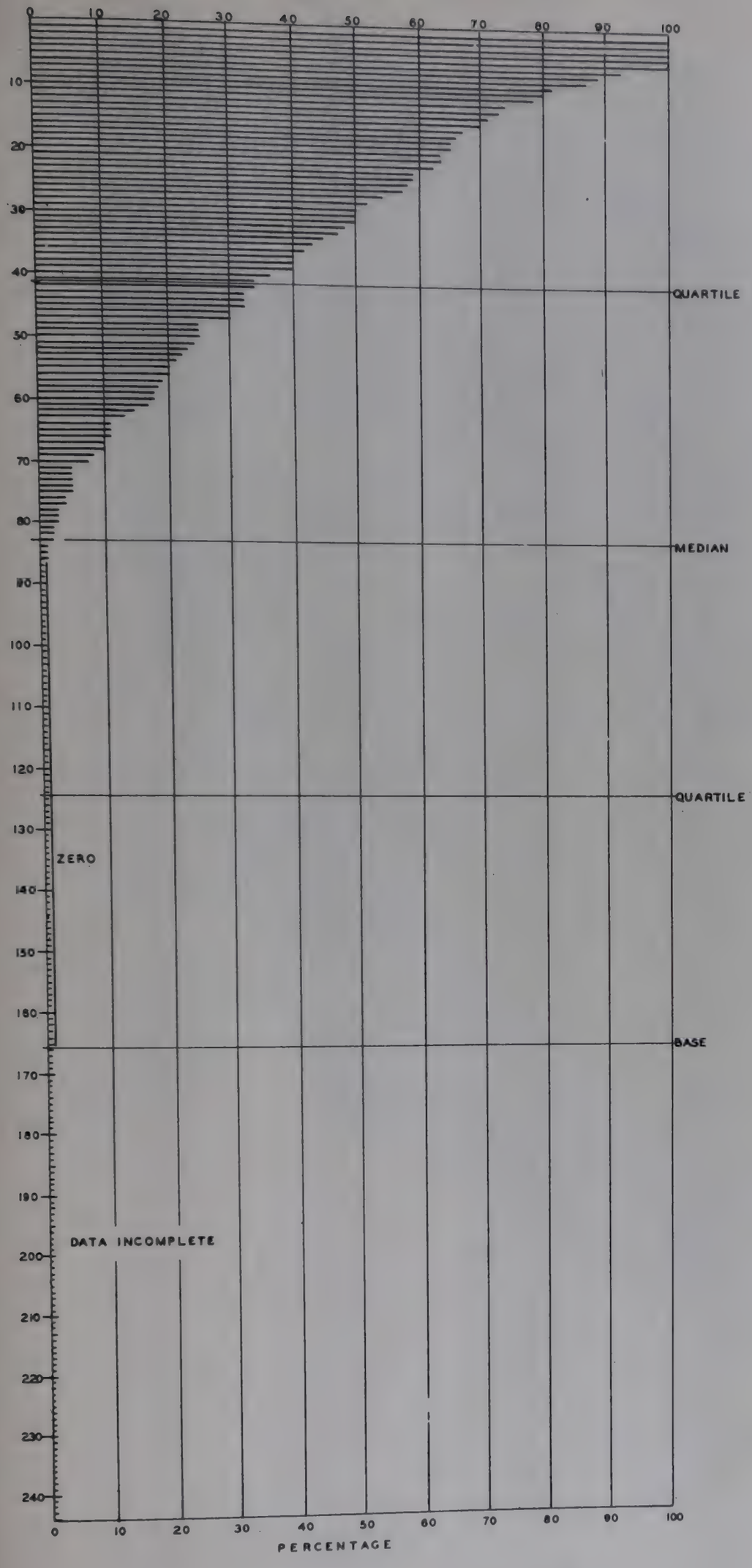
Even recognizing the lenient standards in some areas, it is evident from the chart that much improvement is still possible in the sanitation of public eating places.

The more populous districts report a median of 92., whereas for the smaller areas it is only 72.



FOOD HANDLERS

PERCENTAGE REACHED BY GROUP INSTRUCTION PROGRAM



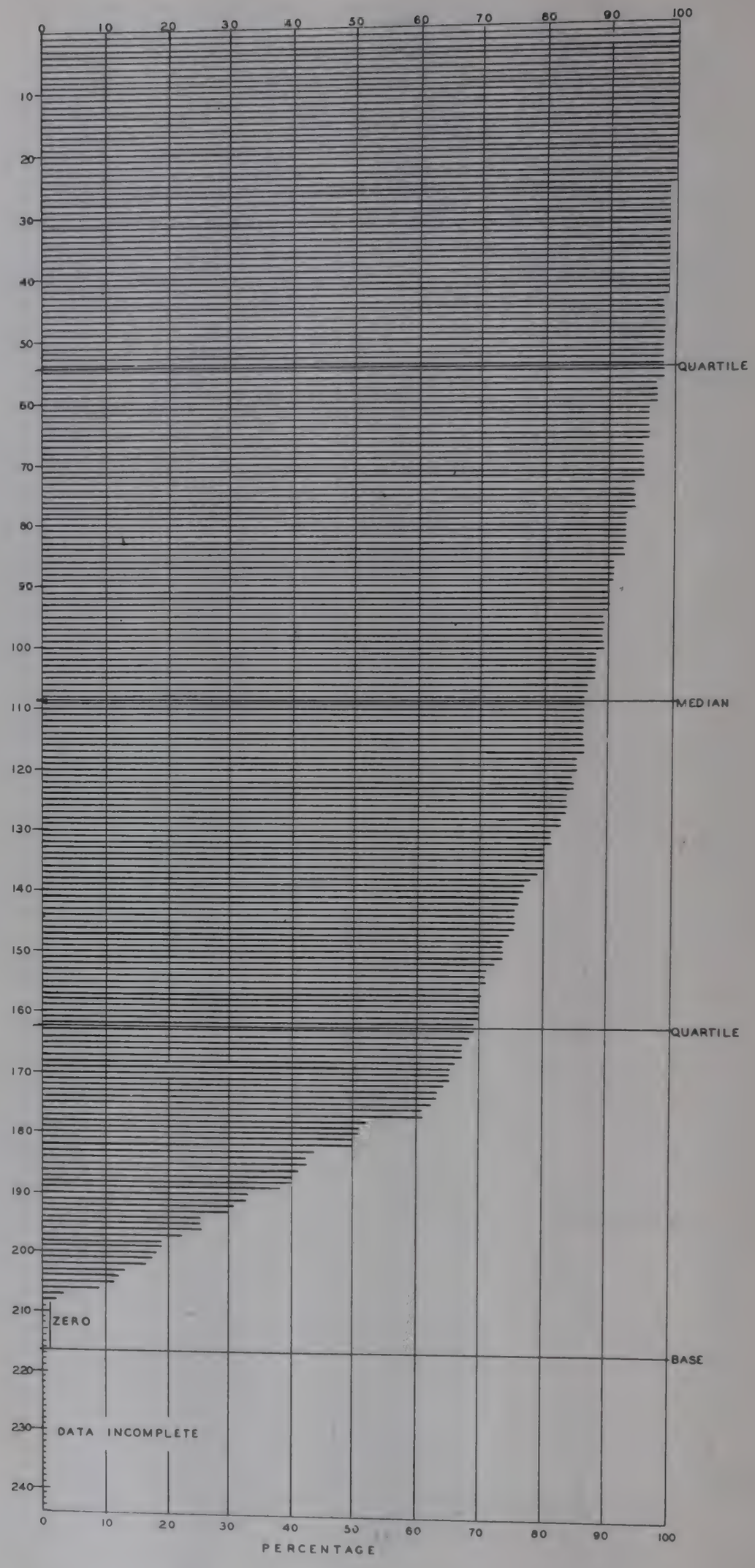
The rapid labor turnover among foodhandlers during these war years has made it extremely difficult for health departments to maintain any systematic group instruction on basic cleanliness and the care of food and dishes. These difficulties are reflected in this chart. Some communities which did conduct courses have reported having to give up this activity due to restricted staff and the pressure of other duties. It is to be hoped that this educational work will be re-established at the earliest opportunity. Elementary instruction of workers and managers in this field is believed by some to be even more important than the medical examination of foodhandlers which is a requirement in numerous areas.

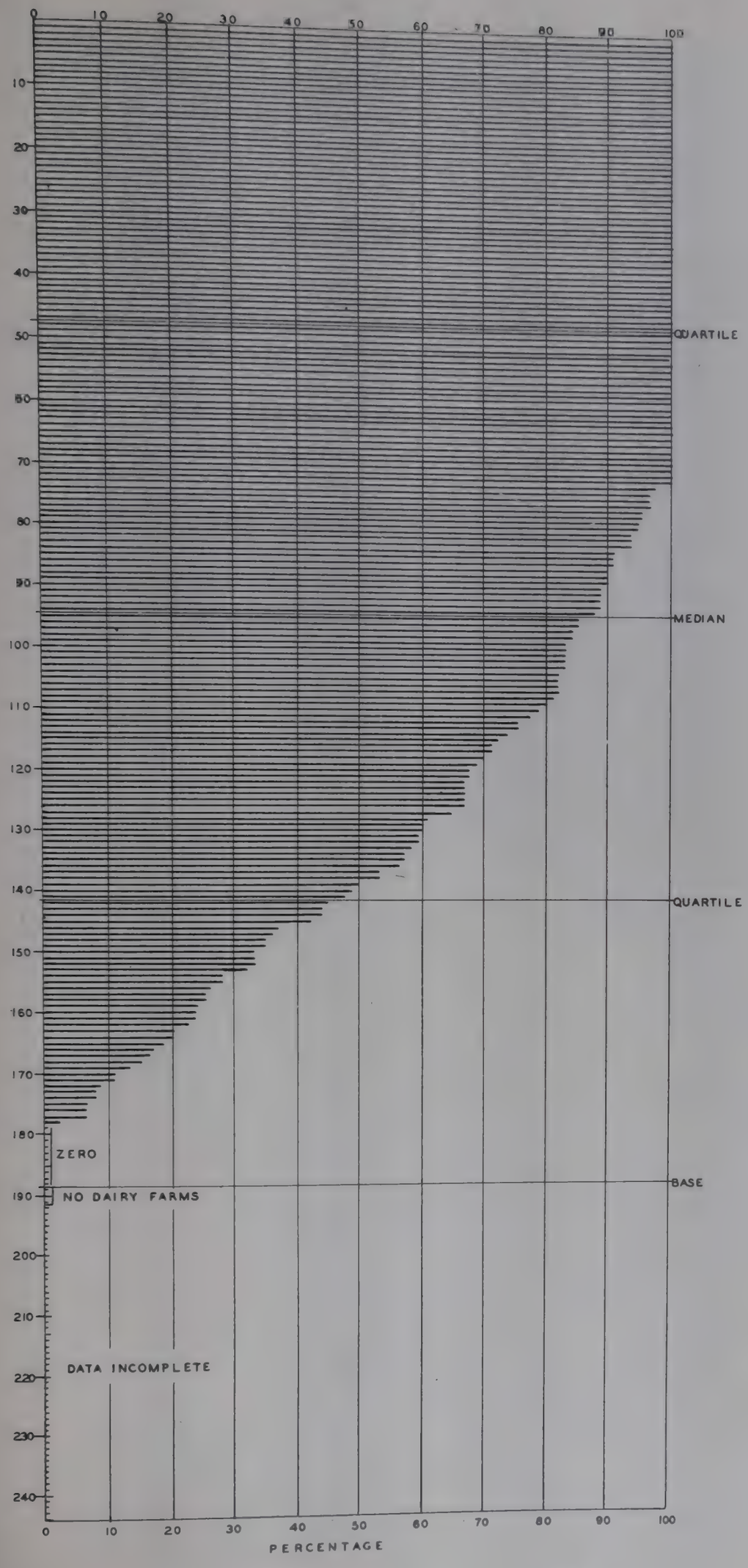
BOTTLED MILK SOLD

PERCENTAGE PASTEURIZED

This chart shows the extent to which communities have succeeded in securing the pasteurization of their bottled milk supply. Twenty-five communities report all bottled milk pasteurized. The median figure for the entire reporting group is 86 per cent. Until universal pasteurization is achieved we cannot expect freedom from undulant fever and those occasional outbreaks of other diseases which may be transmitted through milk. In the year 1943, according to Public Health Reports for May 5, 1945, there were in the United States 40 disease outbreaks transmitted through milk and milk products. These involved 1,590 cases of diphtheria, food poisoning, gastroenteritis, scarlet fever and typhoid fever.

Pasteurized milk is more widely available in the larger areas. The median is 96. In the less populous districts the median is 85.





MILK PRODUCER FARMS

PERCENTAGE WITH APPROVED SANITATION AND HANDLING FACILITIES

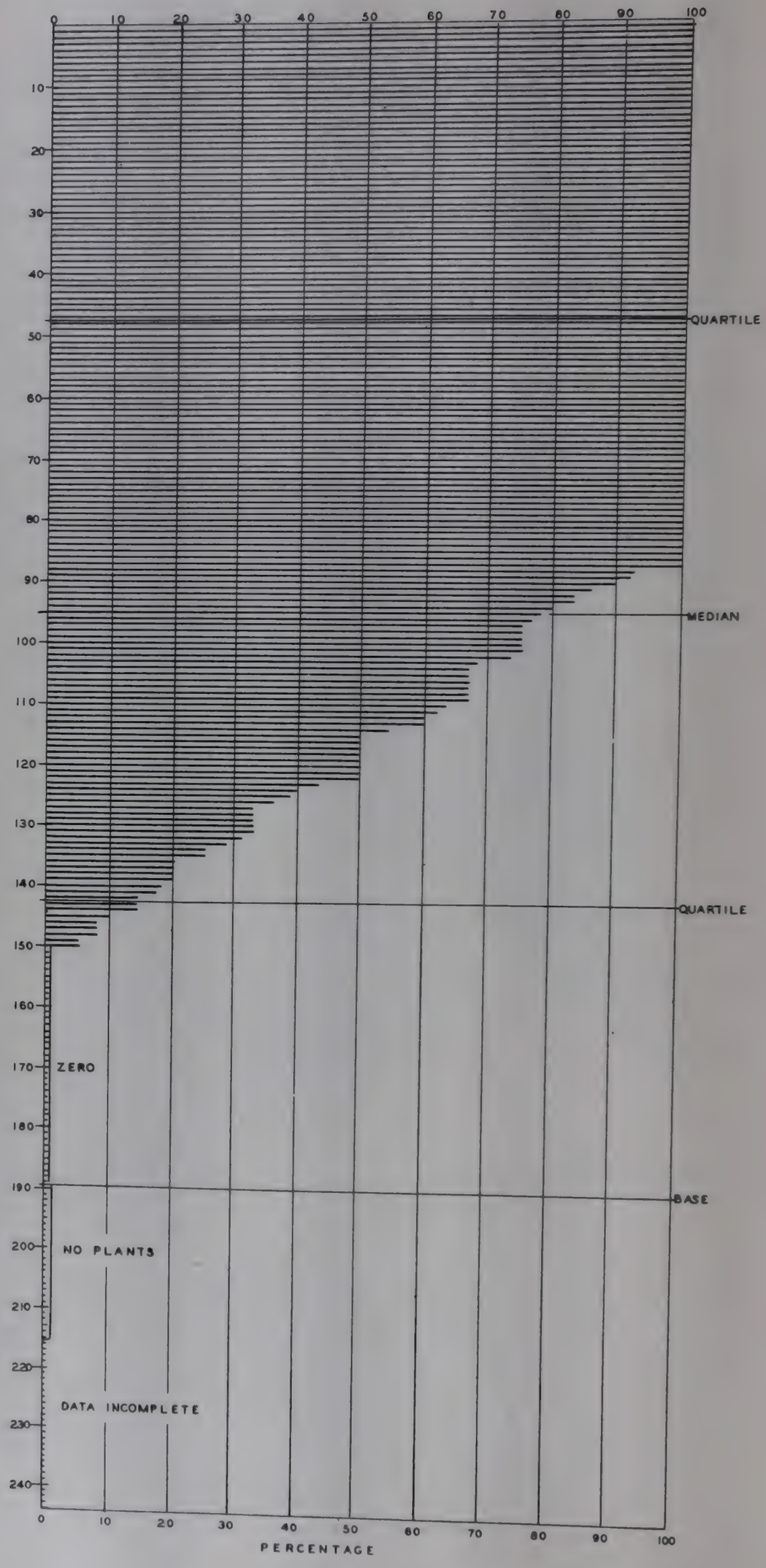
Approved water supplies, excreta disposal methods, cooling facilities and general handling methods on the producing farms are necessary for milk cleanliness regardless of subsequent pasteurization. Seventy-two communities report all their producing farms live up to local standards. Elsewhere farm sanitation shows great need for improvement. A surprisingly large number of health departments are apparently unable to answer these questions.

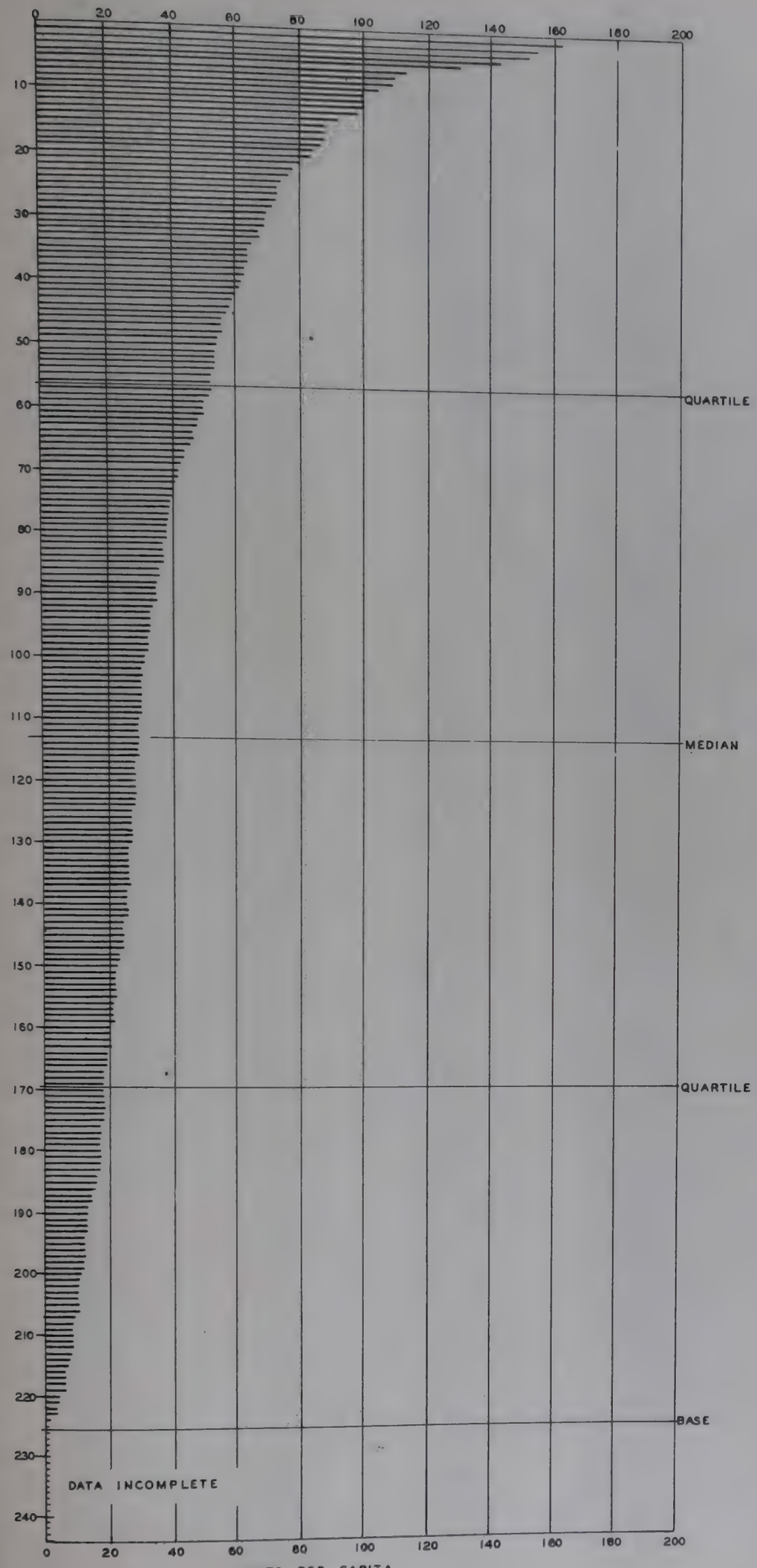
Apparently the larger areas have made greater progress, having a median of 100. In the smaller areas the median is 82.

MILK PASTEURIZING PLANTS

PERCENTAGE WITH APPROVED SANITATION AND HANDLING FACILITIES

The Evaluation Schedule lists eleven items of equipment and operation that are believed necessary for pasteurization plants. If all these details are judged satisfactory by the local health department for all pasteurization plants then the community is represented by a 100 per cent line in this chart. Eighty-seven communities live up to these requirements. Others report deficiencies in some items or in one or more plants. A percentage of 50 means that only half of the plants are completely satisfactory. Before a community can be assured of properly pasteurized milk the details of effective pasteurization must be carried out. For instance, the absence of a recording thermometer is a serious deficiency. Much remains to be done in this field by many communities to provide safety for milk consumers. The median in the larger areas is 100. This is a much better showing than in the smaller areas where the median is only 67.





CENTS PER CAPITA FROM LOCAL SOURCES SPENT BY HEALTH DEPARTMENT

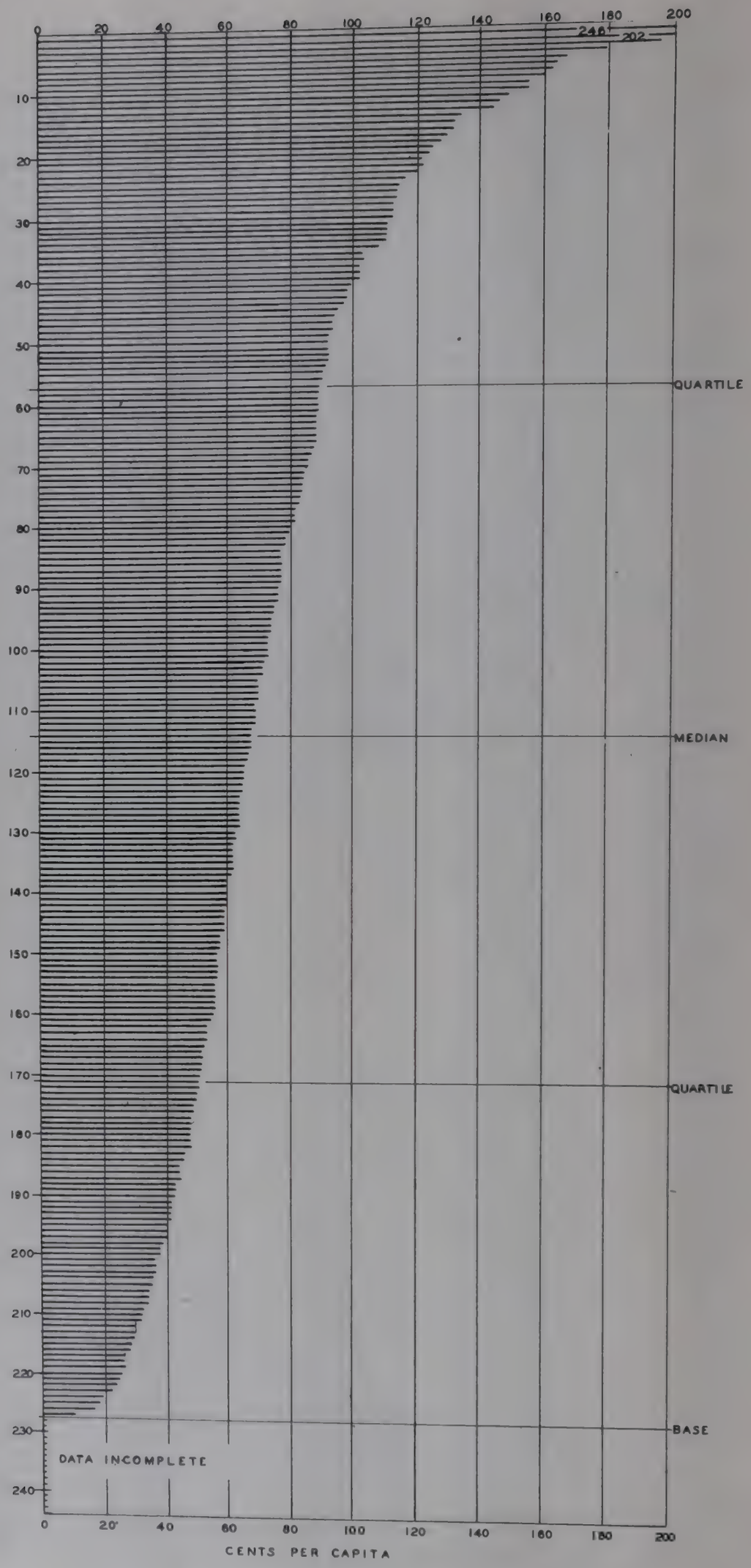
The figure of $1.00 per capita is commonly thought of as the minimum needed to support a reasonably adequate health program and of course in those areas with the more serious and extensive problems, much larger amounts are needed. The median in this chart is only 29.2 cents per capita, or less than a third of the recommended minimum. Only 11 communities reach or exceed the figure of $1.00 per capita. The extremely small budgets in the lower ranges of the chart are wholly inadequate. Supplementation of these amounts within the community, or if this is impossible, from state or federal sources, is necessary to build up adequate health protection.

The contrast between the more populous areas and smaller areas is marked, the respective medians being 55 cents and 27 cents. The large areas provide twice as much money per capita for health department activities.

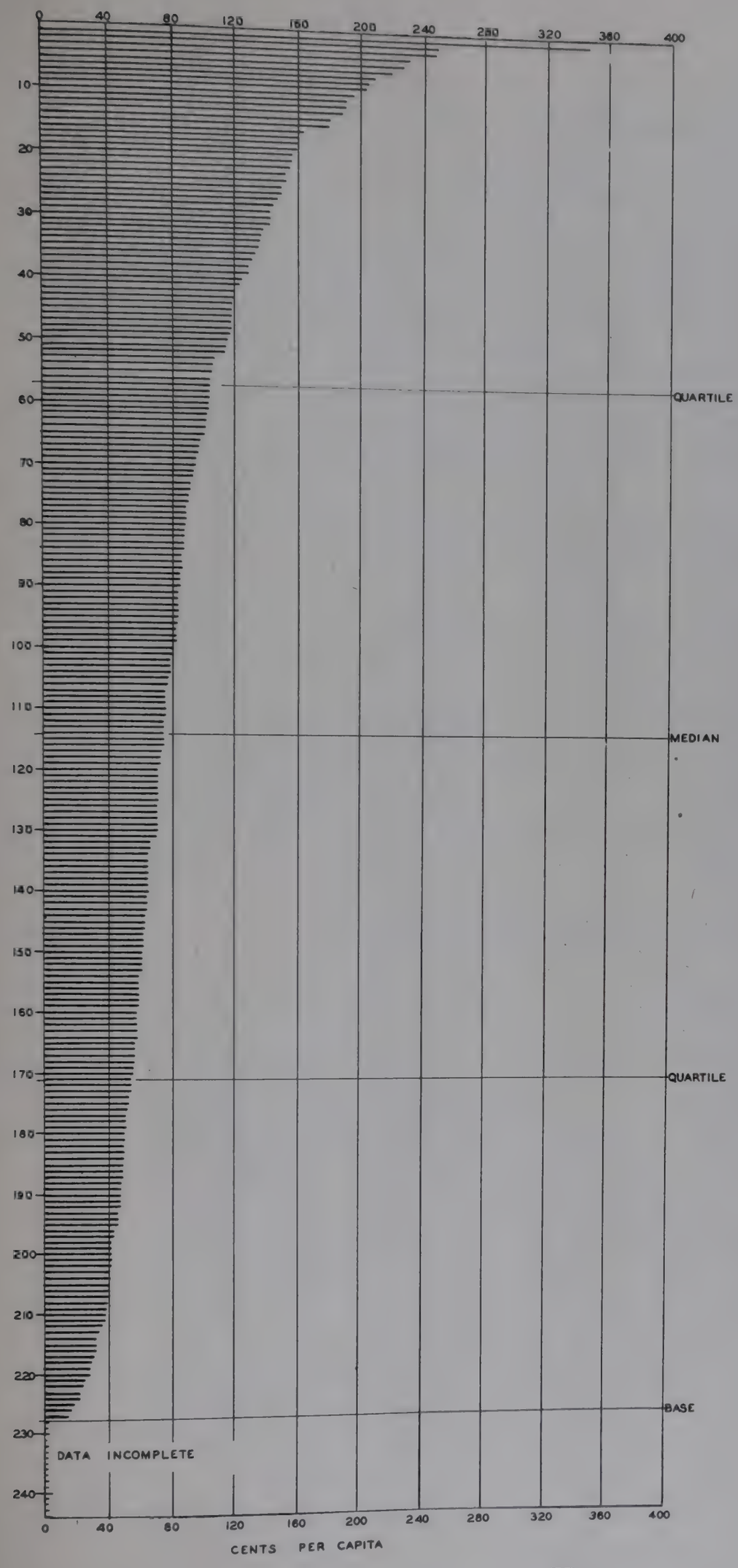
CENTS PER CAPITA FROM ALL SOURCES SPENT BY HEALTH DEPARTMENT

This chart shows a substantial increase over the previous chart. With funds outside the local community, from various sources, federal, state and private, added to local appropriations, the median expenditure is 68.2 cents per capita. These supplementary funds thus account for about 57 per cent of the local health department budget, basing this on the median figures. Even in this instance however, there are still all too many health departments with less than 50 cents per capita for health work.

Outside funds have gone to the smaller areas in greater proportional amounts. Thus the small area budget has been raised from a median of 27 cents to 64 cents per capita. In the larger areas the corresponding increase has been from 55 to 82 cents per capita.



CENTS PER CAPITA FROM ALL SOURCES SPENT BY PUBLIC AND PRIVATE HEALTH AGENCIES



This chart represents expenditures in the area including those of the health department. This covers well recognized public health activities such as those carried on by the board of education (for medical, dental and nursing service), the tuberculosis association, the voluntary nursing association, the clubs and groups supporting special phases of health work. It does not of course include hospital expenditures. It is doubtful that the expenditures other than those of the health department have been reported in a comparable manner in all communities.

The median is 73.3 or only 5.1 cents more per capita than that expended through the health department itself. As health departments become better equipped with funds and with trained personnel and thus able to assume the responsibilities, it is believed advantageous from many points of view to consolidate all health activities within or under the direction of the health department.

GENERAL INFORMATION

MAJOR HEALTH PROBLEMS

Subjects mentioned with greatest frequency by health officers. More than one problem listed by some health officers.

Tuberculosis	147	Housing	36
Venereal disease	136	Additional hospital beds	25
Sanitation	118	Typhus fever	18
Dental service	37		

METHODS OF SECURING COMMUNITY SUPPORT OF HEALTH PROGRAM

Preferred methods mentioned with greatest frequency by health officers. More than one method listed by some health officers.

Formation of health committees	89
Direct approach to lay organizations, clubs, etc.	73
Newspaper articles	61
Personal contact with community leaders	38
No answer to question	33

LOCAL TUBERCULOSIS SERVICES AVAILABLE TO PRIVATE PHYSICIANS

Percentage distribution of each service in 243 communities

Available through	*Consultation*	*X-ray diagnostic service*	*Laboratory*	*Local Pneumothorax Refills*
Health Department	44.	32.	48.	14.
Other agencies	16.	30.	20.	36.
Health department and other agencies	24.	25.	18.	2.
Not available	8.	5.	6.	40.
No data	8.	8.	8.	8.
TOTAL	100.	100.	100.	100.

SYPHILIS AND GONORRHEA

Referral of cases to and from health departments and private physicians

Referred by health departments to private physicians	6,283
Referred by private physicians to health departments	5,523

(Data limited to instances where figures above zero were recorded for both types of referral by 103 communities in 27 states and one Canadian province.)

INDUSTRIAL HYGIENE

CONSULTANT SERVICE AVAILABLE TO INDUSTRY

Administered by —	Communities	
	Number	*Percentage*
State health department only	110	45.
Local health department only	15	6.
State and local health departments jointly	47	19.
Other agency or industry alone	7	3.
No service available	21	9.
No data	43	18.
TOTAL	243	100.

AGENCIES RESPONSIBLE FOR MILK INSPECTION

	Communities	
	Number	*Percentage*
Local health department alone	75	31.
State health department alone	7	3.
State and local health departments jointly	55	23.
State department of agriculture alone	11	5.
State department of agriculture and local health department jointly	61	25.
State departments of agriculture and health and local health department jointly	17	7.
Other combinations of agencies	2	....
No data	15	6.
TOTAL	243	100.

LIST OF HEALTH DEPARTMENTS REPORTING

	Population in Thousands
Alabama	
DeKalb County*	46.6
Elmore County*	32.9
Jefferson County*	479.4
Arkansas	
Little Rock	100.0
Miller County	31.2
Pulaski County	65.0
California	
Fresno	90.0
Long Beach*	221.0
Los Angeles County*	1,250.0
Pasadena	92.3
Riverside County	126.0
Sacramento*	115.6
San Jose*	74.0
San Luis Obispo County*	43.0
Tulare County	117.0
Ventura County	83.0
Yolo County	30.0
Connecticut	
Hartford	182.0
Stamford*	48.1
Florida	
Orange County*	79.4
Illinois	
Adams County	58.8
Cook County	578.0
Decatur*	63.0
Edwards County	8.0
Lawrence County	19.3
Lee County	32.7
McDonough County	25.5
Morgan County	31.7
Wabash County	13.1
Will County	118.4
Williamson County	45.4
Iowa	
Washington County*	20.2
Kansas	
Butler County	31.1
Cherokee County	28.5
Cowley County*	38.1
Douglas County*	27.0
Johnson County	40.7
Labette County*	32.6
Lyon County*	24.8
Marion County	17.2
Montgomery County*	54.0
Riley County	20.7
Topeka City-Shawnee County*	93.0
Kentucky	
Bourbon County*	17.9
Christian County*	45.0
Harrison County	16.0
Lexington-Fayette County	79.2
Louisville-Jefferson County*	445.4
Madison County	29.2
Mercer County	14.6
Warren County*	37.6
Washington County	13.0
Louisiana	
Acadia Parish	43.6
Avoyelles Parish*	35.9
Bossier Parish*	40.6
Caddo Parish-Shreveport City	145.3
Calcasieu Parish	77.0
Claiborne Parish	25.8
East Baton Rouge Parish	112.2
Evangeline Parish*	31.0
Franklin Parish	29.3
Jefferson Parish	65.8
Lafayette Parish	44.0
Lafourche Parish	37.1
Madison Parish	16.2
Natchitoches Parish*	37.9
Rapides Parish	91.6
St. Landry Parish*	76.0
St. Mary's Parish	33.4
Terrebonne Parish	37.1
Vermilion Parish	41.0
Webster Parish	36.6
Maryland	
Baltimore*	930.0
Montgomery County	121.9
Massachusetts	
Melrose	27.8
Pittsfield*	50.0
Michigan	
Alger-Schoolcraft Counties*	16.1
Allegan County	40.2
Barry County	21.3
Battle Creek*	45.0
Bay County*	27.5
Branch County	26.0
Calhoun County	55.0
Cass County*	21.9
Chippewa County*	28.4
Dearborn*	82.0
Delta County*	32.6
Detroit*	1,850.0
Dickinson County*	23.9
District No. 1*	20.5
District No. 2*	24.8
District No. 3	43.5
District No. 4*	50.5
District No. 5	39.5
District No. 6*	15.6
District No. 7*	26.6
Eaton County	36.7
Flint*	151.5
Genesee County*	83.7
Grand Traverse-Leelanau Counties*	32.6
Hillsdale County	29.8
Houghton-Keeweenau-Baraga Counties*	61.0
Ingham County*	58.1
Iron County*	16.4
Isabella County*	26.0
Jackson*	55.0
Kalamazoo City-County*	101.7
Kent County*	83.5
Manistee-Benzie Counties*	26.7
Mason County	19.6
Mecosta-Osceola Counties*	28.6
Menominee County*	22.6
Midland County*	29.5
Monroe County	65.0
Muskegon County*	105.0
Oakland County*	199.8
Ottawa County*	61.2
Saginaw County	51.5
St. Joseph County*	32.0
Sanilac County*	28.5
Shiawassee County*	40.0
Van Buren County	32.2
Washtenaw County*	80.0
Wayne County	394.0
Wexford County*	16.6
Minnesota	
Rochester	28.0
Mississippi	
Coahoma County*	48.9
Grenada County	19.0
Jones County	52.5
Lauderdale County	60.6
Leake County	20.4
LeFlore County*	53.4
Pike County	36.2

* Schedule for the year 1943

LIST OF HEALTH DEPARTMENTS REPORTING (cont.)

	Population in Thousands
Mississippi (*continued*)	
Prentiss County	19.1
Union County	22.0
Washington County	64.7
Yazoo County	41.2
Missouri	
Greene County*	29.3
St. Louis County	218.1
Nebraska	
Lincoln	482.0
New Jersey	
Newark*	429.0
Orange*	35.8
Regional Health Commission No. 1	11.3
New York	
Schenectady*	105.0
North Carolina	
Forsyth County	47.7
Gaston County*	90.1
Greensboro*	61.0
Ohio	
Lorain County*	44.4
Summit County*	78.0
Oklahoma	
Atoka County*	20.1
Blaine County	15.3
Bryan County	31.7
Carter County	33.8
Cleveland County	28.4
Creek County	41.3
District No. 4	58.3
Kay County	44.3
Logan County	21.1
Oklahoma County*	40.8
Okmulgee County*	48.0
Payne County*	36.4
Pittsburg County*	48.4
Pontotoc County*	39.8
Pottawatomie County*	50.4
Seminole County	36.5
Tulsa*	180.3
Oregon	
Baker County	16.0
Clatsop County	31.3
Jackson County*	48.0
Multnomah County	100.0

	Population in Thousands
Pennsylvania	
Philadelphia*	1,957.5
Reading*	114.6
South Carolina	
Berkeley County*	28.2
Charleston County	167.2
Spartanburg County*	149.8
South Dakota	
Pennington County	25.0
Sioux Falls*	45.0
Tennessee	
Chattanooga-Hamilton County*	187.3
Davidson County	96.6
Gibson County	49.0
Memphis-Shelby County	380.3
Rutherford County	34.2
Sullivan County	76.7
Sumner County	34.5
Texas	
Austin-Travis County	123.4
Bexar County	118.7
Cass County	30.0
Central Texas Unit	156.5
Cooke County	30.0
Corpus Christi County	152.7
Dallas County	156.0
El Paso City-County	150.0
Fort Worth*	218.0
Gaines-Hockley-Terry-Yoakum Counties	46.9
Galveston County	34.0
Gulf District	100.0
Houston	460.0
Hunt County	48.8
Jasper-Newton County*	31.2
Jim Wells County*	21.1
Lamar County	52.0
Laredo-Webb County	48.0
Medina County	16.4
McKinney-Collin County	42.5
McLennan County	113.0
Milam-Robertson Counties	60.0
Nolan County	19.0
Orange County*	48.6
Palo Pinto County	20.5
Port Arthur	56.0
San Antonio	330.0
Southwestern Unit	42.9
Tarrant County*	47.9

	Population in Thousands
Texas (*continued*)	
Taylor County	51.1
Texarkana-Bowie County*	58.7
Tyler-Smith County	91.0
Upshur County	22.5
Weatherford-Parker County	22.0
Utah	
Logan*	12.0
Washington	
Clarke County-Vancouver City*	100.0
Tacoma*	140.0
West Virginia	
Marion County	68.6
Monongalia County	53.0
Wetzel County	22.4
Wisconsin	
District No. 1	271.2
Green Bay*	45.8
LaCrosse*	42.7
Madison	72.2
Milwaukee	602.0
Racine*	67.5
Rock County	26.2
Sheboygan	44.7
Wausau	29.5

CANADA

British Columbia	
Peace River Block*	12.9
Manitoba	
St. Boniface*	18.6
St. James-St. Vital*	25.6
Ontario	
Hamilton	175.4
St. Catharines	34.6
Timins*	24.0
Quebec	
Arthabaska County*	31.3
Brome-Missisquoi Counties*	34.9
Nicolet County*	30.6
Shefford County*	34.9

* Schedule for the year 1943

RANGES, MEDIANS AND QUARTILES

	Departments reporting	Range	Median	Upper quartile	Lower quartile	Median: Communities over 100,000	Median: Communities under 100,000
HEALTH DEPARTMENT PERSONNEL							
Population per full time medical officers (in thousands)	242	11.3-652.5	43.8	28.3	77.5	100.0	37.6
Population per full time public health nurse (in thousands)	242	2.3-91.0	10.8	7.4	15.6	12.7	10.4
Population per full time sanitarian (in thousands)	242	3.1-289.0	24.2	16.7	34.9	19.2	25.0
Population per full time clerk (in thousands)	242	3.1-118.6	18.6	13.4	29.8	16.0	19.0
GENERAL HOSPITALS							
Beds per 100,000 population	217	0-1881.5	297.0	538.4	178.8	438.5	262.6
COMMUNICABLE DISEASE							
Diphtheria: Cases per 100,000 population, five year period	213	0-75.0	9.7	3.4	19.1	10.8	9.5
Diphtheria: Deaths per 100,000 population, five year period	212	0-7.4	0.6	0	1.6	0.6	0.6
Whooping cough: Deaths per 100,000 population, five year period	208	0-9.9	1.3	0.6	2.8	1.2	1.4
Malaria: Cases per 100,000 population, five year period	200	0-2568.5	0.6	0	5.5	0.7	0.5
Typhoid fever: Cases per 100,000 population, five year period	209	0-165.5	4.2	1.6	11.2	3.2	4.4
Typhoid fever: Deaths per 100,000 population, five year period	215	0-8.6	0.4	0	1.2	0.4	0.4
Typhoid and paratyphoid fevers investigated: Percentage of sources found	155	0-100.0	47.4	100.0	19.5	59.2	41.5
TUBERCULOSIS							
Deaths per 100,000 population, five year period	203	2.9-115.6	31.1	18.6	49.1	29.5	44.4
Cases reported per death, five year period	189	0.9-17.2	2.3	3.0	1.8	2.2	2.3
Newly reported cases: Percentage in minimal stage	197	0-100.0	23.1	36.4	13.9	24.3	22.7

RANGES, MEDIANS AND QUARTILES (cont.)

	Departments reporting	Range	Median	Upper quartile	Lower quartile	Median: Communities over 100,000	Median: Communities under 100,000
TUBERCULOSIS (*cont.*)							
Active cases on register: Percentage at home at end of year	207	0-100.0	48.5	25.0	76.0	51.0	44.4
Active cases at home: Percentage due to lack of hospital facilities	177	0-100.0	0	0	25.0	0	15.8
Contacts of register cases: Percentage examined with x-ray	180	0-100.0	59.6	80.5	43.2	44.0	60.5
Newly reported cases: Contacts per case reported	194	0.1-13.3	2.8	3.7	2.0	2.6	2.8
Contacts of newly reported cases: Percentage examined	191	0-100.0	73.9	92.6	52.6	74.4	63.5
Newly reported cases: Percentage visited by nurse within one month	197	0-100.0	90.3	100.0	65.5	82.4	93.1
Register cases: Percentage of homes visited by nurse in the year	172	1.7-100.0	84.3	100.0	64.4	84.3	84.6
Active cases reported before death: Percentage hospitalized within two months of report	185	0-100.0	58.3	81.8	25.0	63.8	57.1
SYPHILIS							
Cases reported: Percentage in early and early latent stages	207	0-100.0	44.9	60.0	32.0	40.7	46.2
Early and early latent cases: Sex contacts reported per 100 cases	160	0-425.0	60.5	106.1	31.7	61.7	60.4
Sex contacts of early and early latent cases reported: Percentage examined	156	0-100.0	70.9	89.5	50.0	56.6	72.9
Cases reported: Percentage reported by name	174	0-100.0	100.0	100.0	81.1	98.0	100.0
Early and early latent cases under treatment at beginning of year: Percentage adequately treated	164	0-100.0	68.9	89.9	46.7	65.1	70.5
GONORRHEA							
Cases reported: Sex contacts reported per 100 cases	177	0-1532.6	78.0	115.8	44.1	95.0	76.6
Sex contacts reported: Percentage examined	171	0-100.0	65.5	83.6	45.5	51.5	66.7

RANGES, MEDIANS AND QUARTILES (cont.)

	Departments reporting	Range	Median	Upper quartile	Lower quartile	Median: Communities over 100,000	Median: Communities under 100,000
MATERNAL HEALTH							
Puerperal deaths per 1,000 total births, ten year period	150	0-9.2	3.3	2.5	4.7	3.0	3.3
Total births: Percentage in hospital	227	0-100.0	75.6	92.2	50.5	88.4	71.4
Hospital births: Percentage in hospitals whose obstetrical departments meet minimum standards of American College of Surgeons	190	0-100.0	97.7	100.0	54.6	97.2	98.0
Women delivered: Percentage known to have had antepartum medical supervision	162	0-100.0	52.4	87.2	14.6	48.8	55.7
Women known to have been under antepartum medical supervision: Percentage under supervision before sixth month	123	0-100.0	59.6	77.0	43.9	55.2	60.8
Women delivered: Percentage under antepartum nursing supervision	217	0-100.0	17.6	30.7	8.9	12.4	19.2
Women delivered at home: Percentage known to have had postpartum nursing supervision	171	0-100.0	21.7	48.9	8.3	20.5	22.0
INFANT HEALTH							
Deaths under one year of age per 1,000 live births, five year period	200	10.7-92.0	41.3	34.2	48.4	37.8	41.4
Deaths under one month of age per 1,000 live births, five year period	164	8.4-44.4	25.1	22.3	29.0	25.1	25.1
Diarrhea and enteritis deaths under one year of age per 1,000 live births, two year period	190	0-42.3	1.6	0.6	3.1	2.1	1.4
Premature births: Percentage for whom incubators were used	137	0-100.0	79.3	100.0	50.0	82.4	77.4
Children under one year: Percentage under medical supervision	171	0-100.0	28.3	58.2	13.0	36.4	25.5
Children under one year: Percentage under nursing supervision	198	0.5-100.0	28.6	63.6	15.6	28.5	28.7
Children under one year: Percentage visited by nurse within one month	176	0-100.0	15.8	32.9	7.2	15.5	15.8

RANGES, MEDIANS AND QUARTILES (cont.)

	Departments reporting	Range	Median	Upper quartile	Lower quartile	Median: Communities over 100,000	Median: Communities under 100,000
INFANT HEALTH (*cont.*)							
Children under two years: Percentage given immunizing agent against diphtheria	197	1.1-85.0	17.6	32.2	9.4	21.5	17.5
Children under two years: Percentage vaccinated against smallpox	166	0-83.7	8.0	17.5	3.3	10.9	7.0
PRESCHOOL HEALTH							
Children under five years: Percentage under medical supervision	179	0.3-100.0	9.0	23.6	4.2	7.3	9.6
Children two through four years: Percentage under dental supervision	86	0-94.7	4.8	14.8	0	5.7	4.4
Children under five years: Percentage under nursing supervision	211	0.3-100.0	10.0	21.5	3.5	6.5	10.9
Children under five years: Percentage given immunizing agent against diphtheria	195	4.6-92.0	30.4	51.2	19.1	39.5	30.0
Children under five years: Percentage vaccinated against smallpox	171	0.4-89.1	17.0	29.9	8.2	21.3	15.3
SCHOOL HEALTH							
Entering school children examined: Percentage with parent present	150	0-100.0	49.2	84.3	20.5	54.3	47.0
Elementary school children: Percentage receiving corrective dental work	121	0-95.8	17.2	35.1	5.6	24.3	14.9
School children: Percentage attending schools with hot lunch facilities	170	0-100.0	35.0	61.9	20.1	52.5	33.3
ACCIDENTAL DEATHS							
Total accidental deaths per 100,000 population, five year period	160	18.7-164.7	64.7	50.7	83.3	62.9	65.0
Motor vehicle deaths per 100,000 population, five year period	155	1.3-57.6	19.6	13.6	30.0	18.2	20.0

RANGES, MEDIANS AND QUARTILES (cont.)

	Departments reporting	Range	Median	Upper quartile	Lower quartile	Median: Communities over 100,000	Median: Communities under 100,000
WATER SUPPLIES AND EXCRETA DISPOSAL							
Population in communities of more than 2,500: Percentage served with approved water supplies	208	0-100.0	98.0	100.0	91.1	99.5	97.0
Population in communities of 1,000-2,500: Percentage served with approved water supplies	127	0-100.0	90.0	97.3	75.0	93.0	90.0
Population in communities of more than 2,500: Percentage served with approved sewerage systems	205	0-100.0	89.2	95.8	75.0	91.8	88.0
Population in communities of 1,000-2,500: Percentage served with approved sewerage systems	125	0-100.0	60.0	82.6	16.7	75.0	55.3
Rural school population: Percentage served with approved water supplies	152	0-100.0	75.0	91.5	52.0	88.8	72.3
Rural school population: Percentage served with approved means of excreta disposal	150	0-100.0	88.4	99.4	63.8	93.3	87.2
Public camps, hotels and resorts: Percentage served with both approved water supplies and approved means of excreta disposal	160	0-100.0	96.4	100.0	66.7	100.0	89.7
FOOD CONTROL							
Restaurants, lunch counters and taverns: Percentage with approved sanitation and food-handling facilities	183	0-100.0	74.8	95.4	39.9	91.5	72.3
Foodhandlers: Percentage reached by group instruction program	165	0-100.0	1.5	33.3	0	10.1	0
MILK CONTROL							
Bottled milk sold: Percentage pasteurized	216	0-100.0	86.3	97.6	69.1	96.4	84.7
Milk producer farms: Percentage with approved sanitation and handling facilities	188	0-100.0	86.4	100.0	46.2	100.0	81.6
Milk pasteurizing plants: Percentage with approved sanitation and handling facilities	189	0-100.0	77.8	100.0	14.3	100.0	66.7

RANGES, MEDIANS AND QUARTILES (cont.)

	Departments reporting	*Range*	*Median*	*Upper quartile*	*Lower quartile*	*Median*	
						Communities over 100,000	*Communities under 100,000*
HEALTH DEPARTMENT BUDGETS							
Cents per capita from local sources spent by health department	225	0-161.6	29.2	51.8	18.4	54.8	26.6
Cents per capita from all sources spent by health department	227	9.5-246.0	68.2	89.3	49.6	82.4	64.0
PUBLIC HEALTH AGENCIES							
Cents per capita from all sources spent by public and private health agencies	227	16.4-345.8	73.3	103.4	54.3	94.4	69.5